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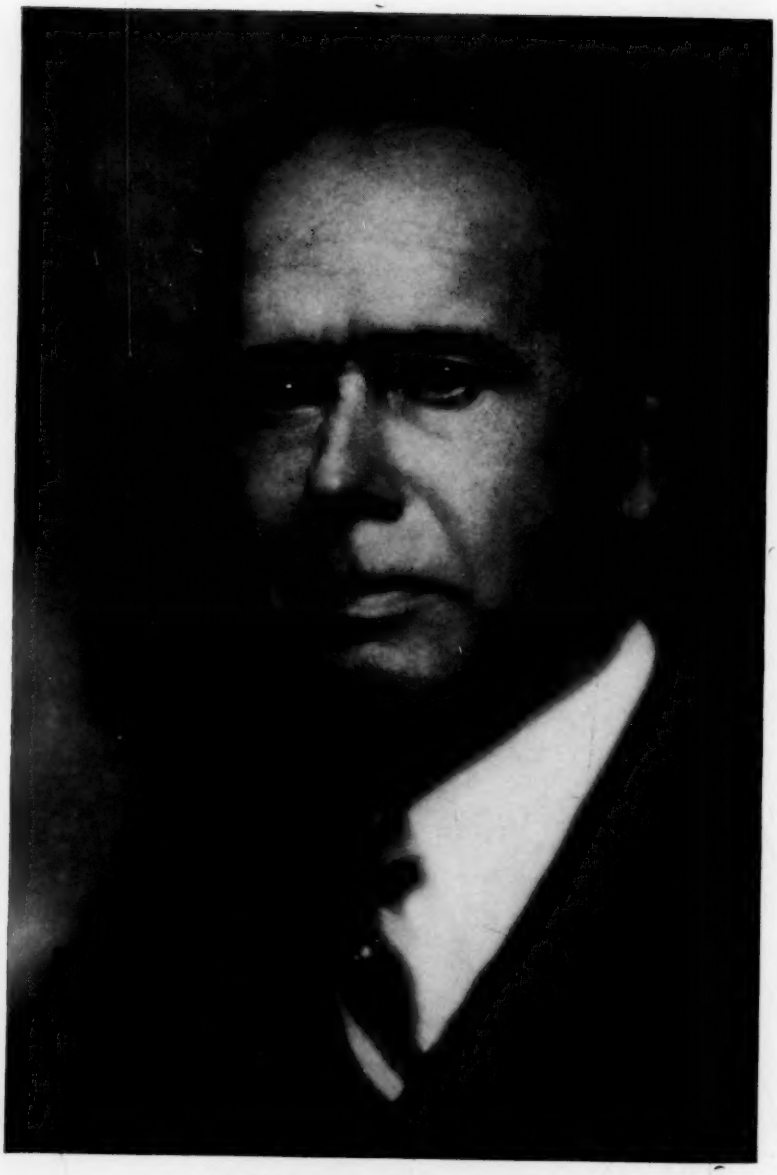

CLIFFORD WHITTINGHAM BEERS
1876–1943

It is with deep sorrow and regret that we announce the death, on July 9, of Clifford Whittingham Beers, founder of the mental-hygiene movement and of The National Committee for Mental Hygiene.

George S. Stevenson

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THE ADOLESCENT IN A WORLD AT WAR *

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EVEN in normal times the burden of adolescence is great. Those who have studied the problems of adolescents who are considered normal have found that they are subject to many conflicts, fears, disillusionments, and frustrations undetected by the adult. And if the behavior difficulty is overt, the adult world—teachers, parents, older siblings—tolerates it less than similar behavior in a child. Perhaps the impatience of adults with adolescents is due to the vacillations, inconsistencies, and unpredictabilities that characterize their behavior.

Psychologically, adolescence, starting with the age of twelve and generally considered to end somewhere between the ages of eighteen and twenty-one, is known as the "storm-and-stress period" and is set apart from childhood, on the one hand, and adulthood on the other. It is a transitional stage between childhood and adulthood, an adjustment process fraught with many difficulties. There are certain overt behavior symptoms in this adolescent period that are characteristic, such as rebelliousness, impulsiveness, inconsistency, the effort to disengage one's self from family ties, and physiological manifestations that have been well established in fact.

The adjustments in the emotional sphere that the individual

* Prepared for the National Conference of Social Work, Child Welfare League of America Session, Cleveland, Ohio, May 25, 1943. The conference was cancelled by the Office of Defense Transportation.

is called upon to make in this transitional stage between childhood to adulthood are frequently profound. The world is uncertain whether to treat the adolescent as a child or as a young adult. Parents do not understand his conflicts over the effort to free himself from their solicitude and direction.

A characteristic of the adolescent that needs to be noted especially in relation to the dislocations incident to the war is that of identifying himself with parents as children do. During a war period, however, this process of identification is likely to be impeded by the fact that parents spend less time with their children, because of the migration of fathers to war-industry communities, or the preoccupation of both fathers and mothers with the new economic opportunities that are becoming available or with voluntary activities of a war-connected nature. The difficulties of transportation to and from places of employment and the fatigue of parents upon returning home from increased work responsibilities are other factors that tend to diminsh their effectiveness in the supervision of their children. Many parents, again, are too much interested in recreation for themselves, often after years of deprivation because of unemployment. Frequently adolescents, during the after-school hours, are alone until one or both parents return from work. There is, therefore, ample opportunity for the distortion of parental images, which play so vital a part in the development of normal adolescence.

Adolescents also identify with the age group just above them—the high-school youngster with the college youth, the younger brother and sister with the older sibling. With the gradual disappearance of the older group, particularly the young males, into military service or war-connected industries, these identifications are breaking down and with them many of the ideals of youth. In addition, there is a disturbance in the goals that adolescents seek, motivated by the desire to follow in the footsteps of the older group. For instance, the whole question of going to college is becoming a troublesome one. There has been a vast reduction in college enrollments, not only in colleges for boys, but also in girls' colleges. There is the whole question of whether to prepare one's self for a future career or just to do the thing that seems to offer most at the time, without regard to a future career. The

image of the future, an important motivating force in the life of an adolescent, is becoming vague indeed. Even among girls, there is a very large increase in the number who are leaving high school to go to work.

The fears of adolescents during war are, of course, many. There is the fear of the adolescent girl about her chances of marriage and in general the future that is in store for her. The whole question of sexual morality is distorted, since the teen-age girl begins to feel that sexual immorality and even illegitimacy have become acceptable, not only for the duration of the war, but permanently.

The lack of clarification in our peace aims also affects the adolescent's security and faith in the future. In this connection, it should be remembered that the capacity of the present-day adolescent to function in a secure and sure-footed manner is not too firmly based. During the past three decades, the family and society in general have experienced great shocks which have resulted in disillusionments that have been incorporated into the attitudes of our adolescent youth. During the last World War, we were led to believe that we were fighting a war to end all wars. This, as we are now quite aware, was only an aspiration, an ideal not really meant to be realized by those who were in a position to achieve it. Then we had the depression in the early '30's, lasting for about ten years and taking its toll in family disorganization and individual maladjustment; and more recently, before our entry into the present war, came the betrayal by responsible governments of the democratic ideals so vital to the American adolescent, through appeasement of aggressive Nazism and Japanese and Italian fascism, as well as the betrayal by the leadership group of the best interests of the people and the countries they represented. As we have already indicated, adolescents as well as children are very much affected by the behavior of their elders, whether it be on a local, a national, or an international level.

In spite of the fact that preparation for maturity—emotionally, vocationally, and socially—is no longer the concern of the adolescent to the extent that it was during times of peace, nevertheless, unprepared, he is frequently stimulated into precocious functioning before he is ready. This is illustrated by the employment situation, which is unique in

contrast to what it was two years ago, when it was most difficult to place an older adolescent in any vocational pursuit. At present, adolescents can command high wages, and frequently the new-found wealth is being misused and is the cause of irresponsible action, particularly on the part of those adolescents who until quite recently had been accustomed to a very restricted budget. Only a few years ago it was quite a common thing to find, in large industrial cities, one-third of the employable adolescents unemployed.

Now with regard to the general question of delinquency among adolescents. War releases predatory impulses among them, for during such periods as this, the lid seems to be off and there is an implied sanction for aggressive action. Wars are fought and won by the matching of aggression with aggression, of ruthlessness with ruthlessness. The culture of a nation tends to change from the prohibition of violence to approval of it. When the adult world is engaged in works of destruction, adolescents will, in effect, engage in similar activity, even though it may be inappropriately directed.

If this is not brought about through example, it may be brought about through the opportunities now offered for the expression of those primitive impulses that have been curbed from early infancy and eventually made dormant in the interests of orderly civilized living. We all know that these modifications of conduct are achieved through much sacrifice on the part of the youngster; he has to renounce his impulses toward immediate pleasure-seeking for the benefits to be derived from the delayed expression of such impulses and the consequently greater satisfactions that are thus made possible in civilized culture. When, however, the modifying influences of the adult world itself give sanction to that which was formerly prohibited, these buried urges come to the fore, and the censor (conscience), always operating against pressure from within, becomes sufficiently weakened to permit them expression in the type of behavior that is called antisocial.

Hence we have had an increase in delinquency during this war as during all other wars, both among boys and girls, but in proportion much greater among the latter. There are, of course, other factors of a more specific nature that account for such an increase, whether this increase is recorded in official statistics or becomes the problem of the home, the school, or the clinic.

In war-affected communities, we have the usual conditions brought about by overpopulation and the inability of the community to absorb the newcomers into its own cultural milieu. We have inadequate provision of wholesome recreational resources and greatly overburdened social services, in many of these communities very limited even in times of peace. We have the usual characteristic picture of the boom town—congested housing, crowded living quarters, inadequate schooling, undesirable commercial recreation, a distortion of the ratio between the male and female sexes, resulting in sex delinquencies and the problems of prostitution, and, in general, life on a more primitive level. We also have the spectacle of greater economic opportunities superimposed upon unwholesome social conditions, resulting, not in improved living standards, but in further deterioration.

The question has been raised as to whether there has or has not been an actual increase in delinquency among adolescents, even though it may be conceded that the factors that produce delinquency are prevalent in a war culture. The statistics given out by juvenile courts are, of course, not too reliable as an index of delinquent behavior and certainly not of other forms of behavior maladjustment not designated as delinquent. A more pertinent question perhaps would be not so much whether there has been an increase in official delinquency, but whether there has or has not been an increase in maladjustments among adolescents as a result of the impact of the war. While many of these maladjustments, now the concern of the parent, the teacher, or the preventive social agencies, may not express themselves in delinquency at this time, they may do so eventually, for it is difficult to measure even official delinquency, not to speak of behavior maladjustment, since so much depends upon factors extraneous to the act of misbehavior as such. The relative vigilance of police in different periods of time and in different localities, the degree to which parents are willing to resort to court procedures, the attitude of complainants, and the presence or absence of informal voluntary treatment or preventive social services—which are greatly affected by the war situation, particularly in the matter of the availability of trained personnel—are all important considerations.

Nevertheless, there is ample evidence in the statistics at hand that official delinquency as such has increased, and in

certain communities to an alarming extent, as a result of the war. Even if we take into consideration changes in population, we find the increases such as to give us cause for great concern. In a certain "war-affected community"—"war-affected" both in an industrial and in a military sense—there was an increase of 57 per cent in the number of juvenile delinquents brought to the children's court in the last two-year period. In this same period there was an increase in population of 100 per cent. One might be led to believe that this condition should cause no alarm, since the increase in delinquency was only a little more than half the increase in population. But when the population increase is examined more carefully, it is found that while there was a 100 per cent increase in the total population, there was only a 4 per cent rise in the child population of school age as judged by school enrollment—perhaps due to the fact that to this community have migrated mostly single individuals, childless couples, or perhaps couples with children under school age or the heads of families who left their families behind for the time being. If, therefore, in this community we compare the increased rate in juvenile delinquency as judged by the children's-court statistics, with the increase in the child population from whom delinquents are recruited, we must conclude that about 53 per cent (57 per cent–4 per cent) represents the actual increase in delinquency.

The figures for various parts of the country, of course, differ. The industrial communities of New England and many of the military and industrial areas of the South reveal the largest increases. In New York State, in the war-affected counties (without correcting for population changes), the rise recorded by the State Department of Social Welfare in 1942 over the average for the years 1938 to 1940 is about 22 per cent. In New York City, the figure has been given frequently as an increase of between 11 per cent and 14 per cent if we compare 1942 with 1941, and recently figures have been published that indicate for the month of January, 1943, as contrasted with January, 1941—the pre-war year—a 57 per cent increase. (The increase for girls is recorded as 128 per cent and for boys, as 44 per cent.) We hope that this single month's experience is an unreliable index. In view, however, of the fact that in New York City, during the decade between

1930 and 1940, there was a reduction of 42 per cent in the rate of delinquency per thousand of child population, this trend upward that started at the beginning of 1942 is disconcerting to those who see the implications for the future.

The United States Children's Bureau gives a figure of 6 per cent as the rise in 1941 over 1940; and for 1942 as contrasted with 1941, on the basis of a sampling of juvenile courts, speaks of "a definite increase in the number of cases disposed of." In citing illustrations, the fact that delinquency among girls, especially the sixteen-to-eighteen-year-old group, has increased since the latter part of November, is emphasized by the bureau.

At a recent annual meeting of the Social Hygiene Committee, sponsored by the New York Tuberculosis and Health Association, reports of venereal disease among teen-age girls were particularly distressing. Representatives of the army, the navy, and the United States Public Health Service stated that the professional prostitute is no longer the spreader of venereal disease, but that the teen-age girl who is sexually promiscuous outnumbers the professional prostitute by a ratio of four to one as a spreader of this disease in the New York area. Even if this is an exaggeration, based rather upon impression than upon fact, this statement, coming from competent authority, should be considered with a great deal of seriousness.

The New York City Health Department, in December, 1942, in a comparison of 1942 with 1941, reported a rise of 20 per cent in venereal disease in this city among boys and girls of high-school age, fifteen to nineteen years of age.

In spite of these increases in official delinquency, the volume of work done by the private case-work agencies has generally not increased. In the experience of most of them, however, the cases that come to the attention of those that work with youth represent more serious offenses, such as stealing and sex delinquency, and are of a more organized nature than formerly.

In the large increase reported in England, gauged by comparing the year September, 1938, to August, 1939 (the year before the war), with the year September, 1940, to August, 1941 (after one year of war), the adolescent group had a 50 per cent increase, the girls showing a rise of 92 per cent.

Present reports, however, indicate a marked reduction as a result of the attention given the problem after the trend became a matter of common knowledge. A recent release from the British Information Services states that "the decline is most noticeable in the industrial northern areas, where the Manchester Juvenile Court, for one, shows a 17 per cent reduction in child delinquency when the year September, 1941, to August, 1942, is compared with the year September, 1940, to August, 1941, covering every type of charge."

The problems connected with the employment of youth as the result of increased employment opportunities and the need for man power are becoming increasingly acute. The demands that young people be released from school to work on farms, in stores, in industries and factories, are mounting daily, and the high wages commanded by youth are exerting a strong pull in that direction. An increasing number of young people are leaving school for work, and this trend will be greatly accelerated as the eighteen- and nineteen-year-old boys are drafted. Young people are taking the places of adults who are drawn into military service. Little attention is being paid to the fact that most of these young people are in the formative stages of development and need to look upon work as an educational process in preparation for future responsibilities. Many thousands of young people and even children are combining school with part-time employment of many hours at a stretch, so that it is not uncommon for a youngster to be at work and in school from fifty-six to sixty hours per week.

There is a growing pressure for the breakdown of standards of child-labor and compulsory-school-attendance laws. School authorities report that many students are failing in school because of long hours spent in part-time employment that may last until midnight or even later. It is reported that employment of this type is often in pool rooms, where fourteen-year-old boys, and even younger children, set up pins sometimes until two or three o'clock in the morning. The number of children between fourteen and eighteen years of age who obtained certificates for full-time or part-time jobs in 1941 was more than double the 1940 total; and the number between fourteen and fifteen years of age in this group increased 77 per cent.

United States Children's Bureau and other Federal agencies concerned with the welfare of the children and youth of the nation have promulgated certain principles, most of which have been adopted by the War Man-power Commission, with regard to the employment of young people. Some of these are:

1. No child under fourteen years of age to be employed outside of the home.
2. No child under sixteen years of age to be employed in manufacturing occupations.
3. No child between the ages of fourteen and sixteen to be employed in other occupations in a way that interferes with school attendance.
4. No minor under eighteen years of age to be employed in hazardous occupations.
5. No employment programs for school children that involve release from school or readjustment of the school program unless it has been officially determined after investigation that labor shortage cannot be met in any other way.
6. Available women and men over the draft age to be utilized before youths under eighteen years of age are recruited.

Thus an effort is being made, at least in the form of principle, to protect young workers from harmful occupational pursuits that would interfere with their educational program and general development, and at the same time to take into consideration the man-power needs of a nation at war.

In connection with schooling, it should be noted that we are facing a shortage of from 50,000 to 60,000 elementary-school teachers, largely in rural areas, and in our high schools a very large loss of men teachers is noted. Not only, therefore, will the educational opportunities of our adolescents be curtailed through this shortage, but the need for the male teacher in the educational process of the adolescent will be felt more keenly than ever before.

Now it is becoming increasingly evident that American youth will need to participate actively and in great numbers in the farm program of the nation, in order to replace reduced man power on farms and to meet the increased needs of farm production. It should be possible to combine this essential need with the necessity of giving young people an experience that will contribute to their educational growth and personality development. To achieve this combination, it will be necessary to require that all young people who have had little or no previous experience in farm work receive special preparation and training, continuing supervision on the job, and

personal services while on the job to meet whatever difficulties in adjustment are encountered in this novel experience. The U. S. Children's Bureau, in consultation with the Department of Agriculture and other Federal bodies concerned with the problem, have set up guides for the successful employment of non-farm youth on farms in war-time agriculture. If localities would follow these standards, good production as well as sound educational experience for our young people would result. If these standards are not followed, inefficient production and much harm may result.

In its wider implications, a general program to meet the needs of the adolescents and of youth in general during this period of war calls for the provision of opportunities for participation in the war effort on the home front for boys younger than the lowered draft-age limit of eighteen years, and for girls beyond that age. There are various approaches to meet this need, a number of which are now in operation.

The National Youth Administration[1] is responsible for a constructive and productive enterprise in this area. The administrator of this agency reported that in January, 1943, there was a turn-over of 30,000 young people per month in the training centers; of this number, 17,000 went into war-production industries. The educational needs of the young people are a concern of the National Youth Administration program, and on the basis of testimony rendered by the employing war-production firms, the pre-employment training that both young men and young women receive prepares them to meet their responsibilities adequately in the various specialties. These young people are learning by doing in the local and residence centers under the auspices of the N.Y.A. In the area of pre-employment training, there is also the training program under the sponsorship of the United States Office of Education for those employed by industry and assigned to this program.

From the point of view of the need for an activities program as a war-participating experience, the High School Victory Corps program should also be mentioned. Two objectives for the high schools' war-time program in the form of the Victory Corps are given by the United States

[1] Since this article was written, the National Youth Administration has been abolished.

Office of Education: first, the training of youth for the war service that will come after they leave school; and second, the active participation of youth in the community's war effort while they are still in school.

With regard to the former, an effort is made to modify the curriculum so that it will conform as much as possible to war aims and war needs, including such specific subjects as pre-flight training in aëronautics and pre-induction training for critical occupations. Special competence in science and mathematics, war-time citizenship, and so on are stressed.

With regard to the second objective—participation in the community's war effort—the following possibilities suggest themselves among many others: transportation services, fire watching, assistance in U.S.O. volunteer activities, Red Cross services, salvage campaigns, care of the small children of working mothers, home nursing, first aid, victory gardening, stenographic and clerical assistance to civilian volunteer offices, and so on.

Both through training for actual war service and through participation in the community's war effort, this High School Victory Corps makes an important contribution if it is practiced and put into operation seriously.

The British Information Services describes in detail the many important activities in which youths and the adolescent group, as well as children, are participating in England's war effort. These are very systematically organized, with a variety of specific services. A National Youth Committee was set up at the very beginning of the war to advise the Board of Education and the Department of Education for Scotland. Local authorities were asked to establish youth committees in their respective areas. There are at the present time thirteen nation-wide organizations represented on the Standing Conference of Juvenile Organizations. The Youth Service Corps is of especial interest. It has been organized to do seventy-six different kinds of work of national importance. It is run primarily by the young people themselves. Of note, too, is the Junior Training Corps for boys over fifteen. It is run by regular military personnel and provides training in drill, modern weapons, military intelligence, and so forth.

On the basis of experience, Britain has come to the conclu-

sion that for the development of young people, what is needed is not one uniform organization for national service, but a variety of organizations among which free choice may be made, "which will implement the energetic wish of boys and girls to serve the country." Reports indicate that 75 per cent of the children up to the age of fourteen years are now organized in Britain for war services.

In this country, the Office of Civilian Defense block-plan organization, which is being recommended for all communities, can serve as an excellent channel for giving adolescents a participating experience. As time goes on, the block-plan organization will call for an increasing number of duties in relation to the war effort that will devolve upon the block leader who, in turn, will be able to utilize adolescents and youths as assistants for whatever duties are assigned the block units at a given time.

In many cities the demand for the traditional individual-treatment services rendered on a case-work basis, whether it be by the family agency, by the children's agency, or by the child-guidance clinic, has not increased in volume. When we contrast this situation with the increase in the corrective group—the courts, the institutions, the homes for unmarried mothers, and so on—we must come to the conclusion that a gap exists between the preventive and the corrective services.

Two factors seem to be at work here. One is the weakening of parental supervision due to the distortion of standards of conduct incident to a war culture, with the net result that parents no longer are as much concerned about the misbehavior of their children as they were formerly. When the youngster becomes a problem for the police, then, of course, the matter takes its own course, and we find him or her a client of the corrective group of agencies.

The preventive group, composed primarily of the voluntary private agencies, functions primarily through the coöperation of the parent who is aware of his need and wishes the service for the child as well as for himself. In the absence of this former concern of the parent, and in view of the increase in unacceptable behavior among adolescents, especially among teen-age girls, it would appear that the private agencies need to do a lot of "retooling" in order to get closer to the problem.

This might mean a much greater coöperation with the public agencies than ever before—for instance, the setting up of a counseling and case-work service in department-of-health district clinics for the younger girls who come for venereal-disease treatment. It might mean a much closer relationship with police forces, especially juvenile-aid bureaus, or the women's police group, or crime-prevention bureaus in the police department wherever they exist. It would mean a greater reaching out and becoming concerned with the unreached client who does not necessarily come and ask for treatment or guidance. In midtown New York City, on the West Side, there is the pitiful spectacle of the very young girls of sixteen, fifteen, fourteen, some even thirteen years of age, who accost men of the armed forces.

Some kind of arrangement should be effected whereby the agencies that have professional services to offer may bring such services nearer to the area of potential client need. It might be necessary, for the duration, to leave the intake desk of the agency and—through coöperation with public and official agencies, as well as perhaps through methods adapted to reach clients directly—to play a more significant rôle in the prevention of the youth maladjustment and delinquency that result from the impact of the war.

These conditions are even more aggravated in military and war-industrial areas. The case-work services, be they child care, family care, or child guidance, must become increasingly concerned with offering a counseling service on the problems of the adolescent, whether it be with parents directly or through parent-teachers groups, with teachers in the schoolroom, or with group-work agencies who are finding it increasingly difficult to conduct club activities on the usual basis.

Integration of our services with those of group-work agencies, so that the total personality needs of the adolescent would become our mutual concern, is more imperative now than ever before. Guidance services in the schools, or, if unavailable in the school, by means of case-work counseling rendered by the private agency, are of extreme importance at this time. Those agencies that have attempted this integration between case-work services and those of the group-work agency, or those of the public agency, official and unoffi-

cial, have already found a fruitful field of opportunity for service. For all in all, what is needed at this time is the mobilization of all personal and group services, private and public, in the interest of our adolescents and children, cutting across functional and specialized lines and considering the adolescent's personality needs on a unitary basis. If this were done, we would not have the spectacle of the creation of duplicating war-connected social services while the existing social services, with years of experience back of them, are left out of the central area of the vast social-service need arising out of war's impact. It would also help to bridge the gap that now seems to exist between the preventive and the corrective services.

So much for the community aspects of treatment. With regard to individual treatment of the adolescent, there are a number of specific problems that need to be dealt with. There is the youth who has been rejected at the induction center either for physical reasons or for mental disabilities. An important personal service, together with a plan for preparation for some kind of occupation or effort related to non-military war activity, becomes essential to reduce the effects of the shock experienced. Then there is the need for guidance and treatment of the anxious boy who is concerned about being drafted after he reaches eighteen, uncertain about whether to continue school or work or what trade to study. This type of youngster by all means needs a personal counseling and treatment service.

The treatment of the adolescent who is currently the client of social agencies takes on a new aspect when related to the expanded employment market now prevailing. No difficulty in obtaining jobs is experienced now by boys or girls, even by those who are in the dull group. Jobs from which a number of our emotionally disturbed or dull youngsters were formerly excluded pay as high as $35. or $40. a week. Positively, there is, of course, the bolstering up of the ego due to the opportunity for self-expression. On the other hand, among neurotic, infantile, unstable adolescents, changes in jobs at the slightest pretext are noted. They pass restlessly from one job to another. They earn more than their real abilities warrant, and the problem of adjustment in the future, when the employment opportunities will no longer abound, will be great.

We recall a typical case of a sixteen-year-old girl who presented severe behavior problems in school. She left school promptly on her sixteenth birthday, now earns $25. a week as a typist, has found security through the job, has made many friends, and has shown a marked improvement.

Then we recall the case of the fifteen-year-old boy who presented school difficulties, who obtained a job at $18. a week as a truckman's helper, and who now refuses to return to school. The compulsory-education law is no longer applied as rigorously as formerly.

It is also interesting to note the breakdown of rationalizations in the treatment situation. For instance, the girl who steals persistently and who insists that she does it because of economic deprivations at home no longer has that excuse. Then there is the definitely hostile girl, who often, after she obtains a well-paying job, finds herself unable to separate from her family and gradually faces her underlying dependency, which she was unable to see before. Also it is noted that, in certain instances, ease in obtaining jobs reinforces defiance of parental authority.

It is becoming more difficult at the present time to utilize the status of employment as the criterion of a good adjustment in evaluating our treatment efforts, for it is reported that even mild psychotics are accepted for employment.

With regard to the problem of the adolescent's confusion as to the purpose and direction of his life and his loss of a source of identification with parents, as well as with the age group next above, there are certain observations that might be made as to the direction treatment or counseling of an individual adolescent might take. It seems that the adolescent who is to be prepared for a life after the war should be prepared for a life that is going to be different. He must become accustomed to the concept of change instead of feeding on the security of a past mode of undisturbed living. Phantasies of the past, with all the comforts of home and parents and friends, associated with a peace-time culture, had best not be dwelt on, but the emphasis should be placed on the fact that there will be a world after to-morrow, a world that will be different, yet livable—that, as a matter of fact, might even be a better world, but not the same world as in the past, just as the world after the last war was different from the world before that war. As proof of this one can easily point to older

brothers and sisters or aunts and uncles who have lived through the past war.

It is this kind of assurance, reassurance, and insight-giving in the direction of a future changed world that constitutes perhaps as therapeutic a procedure as one can recommend in the present uncertain period of the adolescent's life. We should also face the problem of the absence of the male as an ego ideal in our treatment programs. Devising methods of treatment by female case-workers and substitutions in the home for male ego ideals become a challenging responsibility for the mature professional women workers of to-day.

The adolescent has always been a rather elusive client for the individual case-worker and clinician because of the transitional nature of the adolescent period, the adolescent's unpredictable behavior, and the conflicting factors in his personality. Case-workers need to learn enough about the normal adolescent to enable them to distinguish between the problems that are incident to growth in adolescence and those that stem from neurotic reactions; for there are many normal conflicts of puberty and adolescence that resolve themselves through growth. There are attitudes and behavior that would be indications of maladjustment in adulthood or even in childhood, but that may be normal to the adolescent. It is the fluctuation between extremes in conduct that frequently confuses the case-worker.

Both during the war and after, there will be many adolescents of neurotic make-up and with emotional retrogression due to the disturbances to which they have all been subjected, and it behooves the case-worker who either now or later works with adolescents to become familiar with the attributes of normal adolescence and to gain skill in therapeutic case-work and counseling service with the adolescent. The case-worker should redouble his or her efforts to make available certain facilities that will be needed in the way of environmental resources for the treatment of maladjusted adolescents during and after the war.

Among these resources should be the development of the foster home in the interest of the adolescent—a problem that has been but partly solved in many communities—and the development of residence clubs for those adolescents who either have no parents or who need to live away from their parents while they are being prepared to live on their own—

residence clubs that would make available a rich social experience and at the same time a personal counseling service on a case-work level for those requiring it.

Also, the case-worker working with the adolescent should become acquainted with the important movements for the socialization of laws that have to do with antisocial conduct among the adolescent group. It is a paradox that, while legally the adolescent under the age of twenty-one in most states has civil protection as well as civil limitations—in the exercise of the right to manage property, the right of contract, the right to vote, and the right to marry—he does not receive criminal protection in most states if he is over the age of sixteen. We treat the young person as a child in civil law and social matters, but as an adult in criminal law.

There are two main efforts to establish the identity of the status of adolescence and to make the law take into consideration the emotional, physiological, and mental aspects of this stage of development, as children's courts do for youngsters up to the age of sixteen in most states and in some states up to the age of eighteen. One is the Youth Correction Authority Act. This has been enacted in one or two states in a modified form, and efforts are being made to pass similar legislation in a number of other states. This act, which has been recommended by the American Law Institute, calls for the limitation of the function of the judge to determination of the guilt or innocence of youngsters between the ages of sixteen and twenty-one, and, with certain exceptions, places the matter of disposition and the nature of treatment in the hands of an authority of professionally competent individuals. This is a marked improvement over the current procedure of adjudication of youths between sixteen and twenty-one years of age by the judge, on the basis of the severity of the antisocial act committed.

The other movement is in the direction of considering the youth of from sixteen to eighteen years of age, not as a criminal in the first instance, but as a "youthful offender," a category somewhat similar to that of "juvenile delinquent" in the case of a child. This is to be achieved by creating a special youth court for this group, in which the procedures, with certain variations, would be similar to that of the children's courts, but with sufficient modification to insure the adequate protection of society from the hardened criminal

youth by a procedure of reference to the criminal court for adjudication on the basis of selection.

The child-welfare worker, the case-worker, the group worker, and the institution worker will have to cope with the problems of post-war adolescence and the youth of to-morrow in the light of the reorientation that will have to take place in social values, which, of necessity, become damaged during times of war; also in the light of the degree to which our peace aims are clarified to give the adolescent a feeling of hope and trust. We shall be obliged to cope with the aggressions that have been let loose during this war in adolescents, with the consequences of delayed education, with the frustrations incident to loss of goals. The hate implanted by the necessity of winning the war will be an important factor to be dealt with, whether it expresses itself in delinquency or in neurotic forms of maladjustment. Damaged personalities will be brought for guidance and treatment to our case-work and child-welfare agencies.

Youth will need a philosophy of life to give it purpose and meaning in relation to the struggles it will have to face after the war. The adult, whether parent, teacher, or case-worker, will himself be obliged to have a crystallized philosophy of life with an underlying orientation in the democratic process. Youth may come out of the war either rebellious or broken down in spirit, and in both instances, personal counseling service, whatever form it takes, will be required as a corrective influence. Both of these conditions—rebellion against authority and submissiveness—become fruitful areas for exploitation by the demagogue and for the development of the "isms" that characterized the youth movements of fascist European countries just before the war.

There is no guarantee that democracy will be preserved and fostered if we do not make sure that the adolescent of to-day will become the mentally sound and emotionally healthy adult of to-morrow. For, in the last analysis, a political unit can never excel in quality the capacity of its constituents for self-management, and adults who in their childhood or adolescence are subjected to conditions that result in personality distortion, uncorrected and untreated, are thereby hampered in their capacity for such self-management, and hence in their contribution toward the democratic way of life.

CHILDREN'S PLAY IN WAR TIME

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ALL children dramatize in their play their inner needs, compulsions, and interests. Their spontaneous play centers around those life activities that they have most recently observed, those that have made the most vivid impression upon their young minds, or those with which, for some reason, they happen to be concerned at the moment. Although some children may not themselves feel a need to engage in a specific type of activity, their play may be determined by the play activities of other children with whom they come into contact and whose spontaneous play they imitate. Children's play may thus be motivated either by a child's own inner compulsions and needs, or by a somewhat superficial interest of the moment—that is, by the play pattern of another child, who, however, may be motivated by a real need.

Because the subsequent interests and activities of a child are directly affected by his early play activities and also by the play patterns of his child associates, specific attention should be given by parents, teachers, and others responsible for child training to the problem of children's play activities. A child's play should not be adult-dominated, but, on the other hand, guidance in this field is as important as guidance in reading or in any of the other tool subjects. Play habits have too important an effect upon a child's subsequent development to be allowed to develop entirely undirected.

Spontaneous play and other forms of dramatic activity are merely the outward symptoms of a child's innermost thoughts and phantasies. Whenever a child has an intense emotional experience, he may become excessively preoccupied with some single form of play activity which is associated in his mind with the intense experience. Direct treatment of these symptoms or prohibition of the expression of them will be of little value either in enabling the child to solve his emotional prob-

lem or in interesting him in other activities. If this preoccupation becomes so extreme that it interferes with his broad all-round development, we speak of this unnatural degree of preoccupation as a form of neuroticism.

Because this basic neuroticism is expressed in some form whenever the child is free to engage in spontaneous play, an experienced observer is able to obtain much information regarding the mental health of a child simply by studying the child's spontaneous play activities. It is the function of those individuals in charge of child training to detect these early symptoms and to correct the basic difficulty before the child's entire personality has become warped. There is grave danger, however, in the fact that parents and teachers often are unable to distinguish between a symptomatic neurotic preoccupation and a desirable spontaneous play activity; in such cases, the skilled help of clinical psychologists and other specialists in child training must be secured.

Whenever a child who is preoccupied with any one form of play activity is found, we who are interested in his welfare are called upon to give all possible help to enable him to free himself from his inner conflict and to help him to advance to more wholesome interests. We do not increase his neuroticism by encouraging those play activities that tend to aggravate the original disturbance.

For example, a seven-year-old child who had had the harrowing experience of seeing his younger brother killed by a truck became extremely fearful of the street and play yard and spent all of his free time dramatizing the fatal scene of the accident. In a case like this, the appropriate treatment was fairly obvious. We did not foster the child's problem by providing him with more and bigger trucks with which to play, and even a doll to make his dramatization more vivid. Rather, by stimulating his interests in more wholesome directions, we tried to reorient him away from his unfortunate experience.

Play that is motivated by a basic neurotic compulsion should be directed in such a way that it will lead to the solution of emotional problems and, what is more, to wider and more wholesome play activities, activities that are socially acceptable to the group in which the child is to live.

Because of traumatic experiences related to the present war, many children now are excessively preoccupied with the

war and with its various unfortunate concomitants, and some of them are absorbed in these problems to such a degree that their preoccupation seriously interferes with other, more normal activities. These children need help and protection against overstimulation; they do *not* need encouragement in their preoccupation, nor do they need more war games and realistic war-play objects to make their neurotic dramatizations more vivid. They do need help in resolving the inner conflicts engendered by the present emergency, but this help can be given only through reassuring information suited to their needs and interests, and, above all, by means of protection from too much undirected and unwise stimulation.

Habitual war play on the part of children is one method of resolving preoccupation with war and war conditions. It should, however, be recognized as such, as a symptom of a basic neuroticism, and not as a desirable or wholesome play activity. Whenever a child is excessively interested in war play, we may be certain that our care and guidance have failed; we may know that we have not provided him with the basic security he requires.

Although in the case of some children realistic war play may be one way of resolving a basic fear complex, such play is ordinarily undesirable. War games are auto-stimulating; they lead to more war games, rather than to other, more varied interests and activities, and for this reason they are less effectual than other forms of activity in relieving the original emotional tension. Other forms of war-time activity —such as participation in stamp drives and in scrap collections—are more desirable means of relieving tension, for these accentuate the positive, rather than the negative, features of the problem. These activities do not increase the original disturbance; they lead to other, wider, more varied, and more desirable interests; and last, but most important, they give the child a sense of belongingness, of identification with his group. These activities give him a feeling that he is making a contribution that is recognized as valuable not only by himself, but also by the social group with which he has identified himself.

The child's interpretation of realistic war games may be different from the interpretation made by an adult, and it is the child's own interpretation, of course, that is the more important. War-play activities are not necessarily bad in and

of themselves, but they do tend to dominate the child's interests, and thus they interfere with, or even prevent, his engaging in more wholesome activities.

Direct prohibition of war play is ineffectual. If the child is truly preoccupied with an emotional complex, the direct prohibition may merely drive the impulse and the preoccupation into other forms of undesirable expression, but, in so doing, it will also add a strong sense of guilt to the already disturbing fear complex. These basic neuroticisms need to be corrected and resolved, not driven under cover and intensified.

In helping a child derive maximum benefit from his play activity, a wise selection of toys or play apparatus is of paramount importance. From an adult point of view, play objects or toys may be either suggestive or non-suggestive. A non-suggestive, or neutral, toy is far more suitable for a child than a suggestive one since, through his vivid imagination, the child is able to make this neutral object serve his immediate needs, whatever they may be. Toys definitely suggestive of war do serve as a means of emotional release when the child feels the need to dramatize this type of activity, but in addition, unfortunately, they suggest war play to him even when he feels no basic need nor desire for this type of activity.

For example, a simple, non-suggestive object such as a stick may serve as a walking cane, as an aëroplane, as a gun to shoot buffalo, or as a tommy-gun to kill Japanese soldiers, depending upon the needs of the moment. A fancy, painted, wood-and-tin tommy-gun, however, is good for only one thing—as a tommy-gun to kill Japs. It cannot be used in other forms of play, even on an imaginary Indian. The child with such a toy will, therefore, be forced to limit his play activities to the extremely narrow range of the specifically suggestive play object. If he has only war toys, he can play only war games. If he has a liberal supply of neutral, non-suggestive play objects, he can still play war games if he is so motivated, but his toys do not continually restrict him to this narrow field.

As we have seen, excessive preoccupation with war activities is indicative of a serious emotional disturbance, and it represents a problem not easily solved. Forcible prohibition of war games is not the solution; in fact, no easy solution is

available. Only by means of a gradual process of reëducation and development of other interests can genuine improvement be effected.

Because the treatment of such a basic neuroticism is a difficult matter, once it is fully developed, much of our interest lies in *prevention.* A basic and excessive preoccupation with war activities can best be prevented by protecting the child from excessive undesirable stimulation and by helping him to develop a wholesome distribution of interests and activities. The child whose basic need for security in the home, the school, and the community is satisfied will not be unduly preoccupied with any one form of play activity.

In order to reduce the damage done to our children by unusual war-time tensions to the smallest possible extent, and in order to help them develop in as healthy and normal a way as possible, we must, first of all, provide each child with the basic physical and emotional securities without which no child can be free from disintegrating conflicts. In addition, we must supply him with adequate realistic information about the war and the way in which it affects him and his immediate world. This information should be presented unemotionally, and it must be adjusted to his immediate needs and understanding.

As an aid in gaining and maintaining a true perspective, he needs to have before him the example of an emotionally stable adult; he must be led to a realization that the sun will shine again on the morrow. He must be protected against the overstimulation of unnatural war-time conditions. His play activities and the play objects with which he comes into contact should be so supervised and so regulated that they will enable him to resolve his inner fears and conflicts with respect to the war situation, and also so that they will permit his thoughts and his play to advance to other, wider, more useful, and more desirable interests. His activities must not be retained at a single level.

Parents and other supervisors of children's playtime must not confuse the neurotic symptoms which show a preoccupation with war, war-time fears, and insecurities with desirable and spontaneous play activities. Habitual realistic war play must be recognized for what it is in reality—a symptom of a basic neurotic preoccupation with an unresolved emotional conflict.

THE SOCIAL SERVICES IN THE STATE HOSPITALS OF ILLINOIS

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ILLINOIS provides expert hospital care for its mental patients. Our total program of treatment, however, has been inadequate and extravagant, for we have made small provision in the way of preventive measures and have paid meager attention to convalescent care and the rehabilitation of the recovering patient. A typhoid epidemic could not be controlled by giving hospital care to acute cases only. Nor will mental-hospital populations decrease and mental health increase until we utilize, direct, and expand community resources, and treat the sources and conditions from which mental illnesses develop. It is necessary that we accept our total responsibility not only by maintaining our present excellent standards of care for patients in hospitals, but by providing in addition a broad, continuous program of education on all that pertains to mental health, and practical assistance to communities and individuals by means of accessible clinics and an adequate staff of social workers.

The year 1943 will be a year of unprecedented governmental spending. All luxuries will quite rightly become points of attack. Every governmental agency will need to scrutinize its work with an eye to the utmost efficiency and honest economy.

The citizens of Illinois are undoubtedly, and justifiably, proud of our hospitals. Pride in moderation is a fine and useful quality; too much pride can inhibit progress. Honest acceptance of deficiencies is stimulating. It is, then, the duty of the trained personnel to encourage and inspire the pride that begets confidence in our hospitals and in the treatment accorded its patients. It is also our duty to publicize our deficiencies in order that the taxpayer may demand that these be met.

It is, therefore, appropriate for us to acknowledge that we are not yet satisfied either with the economy or with the adequacy with which our jobs are performed. Economy implies spending—spending wisely in order to prevent waste. It is not wise spending to fill our hospitals so full that we cannot provide sufficient doctors for thorough treatment of all. There are now hundreds of patients who receive only custodial care. It is quite possible that even these patients, seemingly deteriorated after long years of illness, might respond favorably to treatment if our doctors were free to consider more carefully their individual needs.

We have indeed made progress in the care and treatment of the mentally ill and the mentally retarded. In the colonial period, the harmless insane and defectives were allowed to roam at large, eating nuts and berries. The more violent patients were locked up in dark prisons. We have encouraged the laymen to forget about these old horrors and to regard our institutions as hospitals well equipped to treat and sometimes to cure.

In so doing, we have achieved a lopsided result, for we have stayed too closely within the hospital walls and have neglected to help our citizens and our communities understand and accept their responsibilities in preventing mental illness and in helping with the rehabilitation of the mentally ill. Consequently, we have, throughout the United States, had a steady increase in the number admitted to hospitals. We have spent generously on their care and treatment and then sent them back to families and communities ill equipped to understand their needs and to give sympathetic aid during their convalescence, with the result that we have been obliged to receive the same patients again for more expensive care and treatment. After several unsuccessful trials, the families refuse to try again; communities become indignant at the suggestion that hospitalization is no longer necessary; and the belief becomes fixed that certain patients can never get along except in a hospital.

A general hospital returns a patient who is convalescing from pneumonia to the care of sympathetic relatives under the supervision of the family physician. Our patients have gone home to what?

Perhaps a physically strong son returns to live with fragile old parents toward whom he feels ambivalent—he wishes to lean on them as he did as a small, spoiled child and he hates them because their fragility makes him ashamed of his own dependency. The parents are totally unable to understand this. They sense his hate and fear his physical strength. Before a social worker can call, they have returned him to the hospital. When next they receive a letter that the patient is ready for convalescence at home, they will not come for him.

Perhaps a devoted wife comes for her husband, who returns with her to his home and small children. The wife is kind and considerate, but she, the home, and especially the children, are his responsibilities. The old conflicts revive with added strength. The guilt that he feels for his own inadequacies is transposed into antagonism for these people who remind him by their very existence of his inadequacy. His wife is frightened. She will not believe the hospital a second time.

A patient may occasionally go to live with a relative who not only is devoted, but also has insight. With a reasonable amount of reassurance and help, this situation could be genuinely therapeutic. Treatment in a community situation is far more difficult and complicated than treatment inside hospital walls. Of what use is a monthly visit from a social worker the family have never met before? We have not given adequate support and help even to intelligent relatives. We have fostered discouragement and a belief that mental patients must remain in hospital.

We are now quite happily lopsided and make progress for the most part in a well-defined circle. We have fine hospitals. We encourage hospitalization. We are very competent and advanced in giving treatment. We treat the sick, but, for the most part, we ignore the sick conditions and attitudes of the world outside our doors. A doctor would not willingly return a tuberculous patient, well on the way to recovery, to work in the day shift of a coal mine. Too often mental hospitals have returned their patients to conditions just as unsuitable to convalescence. Thus we have inspired great confidence—the wrong kind of confidence—a definite belief that the mentally ill can get along only in hospitals and that they cannot recover outside. We have thus steadily increased our hospital populations; we have been able to give less individual-

ized treatment, because we have too many patients; and we have discouraged and alienated our greatest therapeutic aid—a sympathetic and coöperative community.

Not too long ago it was common practice to shun and fear the tuberculous, also. Families took extreme measures to deny and to conceal the presence of such a disease. Deaths from tuberculosis were very high, for treatment and prevention were greatly handicapped by this unhealthy attitude. Decisive progress was not achieved until the medical profession made a concerted attack upon Fear. They spent wisely on a great and continuous program of education.

Treatment of venereal disease was likewise handicapped by ignorance and fear. Again, and much more recently, wise spending on the education of the citizenry has produced astounding results.

We who are paid by the state to give care to the mentally ill must acknowledge the inadequacy of a program that does not utilize and develop the entire resources of the state and of all its people, in order that mental illness may with increasing frequency be prevented, and the mentally ill rehabilitated. We cannot stay within walls if our institutions are to be hospitals rather than asylums for custodial care. We must join forces with educators, mental-hygiene societies, public and private social agencies, churches, and medical associations. We must join forces with them not merely in passive coöperation, but rather with dynamic initiative.

It is our duty to aid the department of education in convincing the taxpayers that wise spending is needed for a revision of our educational system if our children are to be educated for living rather than stuffed with education. Mental illness will surely decrease in direct proportion to the extent that children are taught to live realistically.

A comprehensive and continuous education of the lay public is needed to develop, in the citizenry and in communities, intelligent interest, coöperation, and a sense of responsibility that does not begin and end with commitment. Fear of mental illness and of the mentally ill must be allayed by a well-planned program of lectures, posters, radio addresses, publications, accessible clinics, and all the devices so successfully used in the prevention and treatment of tuberculosis and syphilis.

We need social workers who will not only help the recovering patient adjust in the community, but who will also help the community to adjust to those whose behavior is not thoroughly normal.

Thirty years ago it was not uncommon for two epileptics to alternate Sundays in having a seizure during church service. A few individuals cared for the patient, the service proceeded, and the majority of communicants concentrated politely on the sermon. Children were taught by the relaxed behavior of adults, as well as by words, that epileptics are unfortunates, as indeed they are, whether in a hospital or a church.

Thirty years ago, one James Michael used to appear every spring to prune the grapes and clean the clocks for all the families round about. He doubtless made a poor adjustment to life—perhaps he was a dementia-præcox case, simple type—but no one thought of sending him to a hospital for life. Often it was felt that the clocks did not need cleaning, but always James Michael received bed and board until the clocks were clean enough to please him. James Michael was as much a harbinger of spring as was the robin.

Thirty years ago communities were not so squeamish. Had we begun then to urge hospitalization for treatment, and made it clear that custodial care was only for the potentially dangerous, and for those untidy and delapidated patients who could not be cared for in communities, we would not now be faced with the necessity of teaching our citizens how to regard our James Michaels and other unfortunates with calm understanding. Our patients would not leave the hospital on the road to recovery to return to neighbors who shun them.

Accessible clinics and a department of well-trained social workers are necessary adjuncts to an institution in which the emphasis is on treatment rather than on asylum. These are the liaison agencies, the links between the hospital and the communities. Since the social worker is frequently the only hospital representative known in a community, it is highly important that she be a creditable representative. She must be a person of integrity, of sound, independent judgment and resourcefulness. She must possess a warm, accepting, well-integrated personality. Since her work will be quite largely

pioneering, she will need to have courage, vision, ardor, and perspective. She must be well trained and experienced. Without training of an intensive specialized nature, a kind person can, quite without awareness, be a dangerous meddler. Unskilled meddling is as ridiculous in social work as phlebotomy is in medicine.

A social-service department cannot function independently and as a separate entity. It must relate itself to the hospital in its entirety. Accomplishments that do not serve the hospital are tawdry and without value. On the other hand, it is equally important that the medical staff understand how to use the social services.

We, therefore, propose to sketch the work of the Social Service Department of the Elgin State Hospital during the past year, as illustrative of the scope, the quantity, and the quality of work that can be expected of a small staff of trained personnel. We hope also to point out the deficiencies of our work and to envision a more constructive program that can be carried out only if the social-service staff is adequate.

Organization of Work.—We reorganized the department in March, 1942. The case load was then minimal. From March 1 until August 1, 1942, the in-zone [1] staff was also minimal, consisting of one trained worker and three untrained assistants, with no stenographer. More cases were, therefore, referred per month than could be acted upon. The case load increased until, in September, 1942, a peak was reached of 1,054 active cases. There were gradual shifts in staff, beginning in August, until in November, 1942, we had three trained psychiatric social workers in zone and only one untrained assistant. The case load has decreased in each succeeding month since October, 1942.

From March until November, 1942, Elgin had four social workers working in the Chicago area—one specializing in family-care work and three who supervised parolees and made pre-parole arrangements for Cook County patients only. In November one social worker resigned and has not been replaced.

[1] "In zone" applies to seven counties—Lake, Winnebago, Boone, McHenry, DuPage, DeKalb, and Kane. Two-thirds of the patients at this hospital come from Cook County.

For reasons of efficiency and compromise the work is now divided in this way: All new cases are referred to the chief social worker, who carries at present approximately 440 unassigned cases. An effort is made to limit the loads of all caseworkers in order that they may give the maximum amount of attention to supervision of patients out of hospital and to family-care placements. Action on the 440 unassigned cases is, therefore, restricted to letters and hospital interviews. The chief worker is also responsible for administrative and supervisory work.

Three hundred and thirty-two patients were on parole in Cook County in January, 1943. Two workers could not supervise this number; referred cases are, therefore, being limited on a selective basis to a maximum of 30 per month. Other patients will be referred to the Chicago Community Clinic. This arrangement is not sound, since the clinic, too, is understaffed. In one morning 100 Elgin parolees went to the clinic, where only three psychiatrists and one social worker were available.

The Cook County family-care worker supervises 35 patients, scattered from Wilmette to the far South Side. Her total case load is 81, of whom 46 are the most placeable patients in a long waiting list.

The two in-zone workers—those responsible for family-care placements, parole, and family-care supervision outside of Cook County—cover three and four counties respectively, with approximately 80 cases each, and a long list of those awaiting family-care placement.

Intake and Scope.—We have to date had only one "intake" policy—to accept every referred case that a social-service department should accept. Other hospitals have adopted more realistic policies. One hospital does much of its parole supervision by mail and by requiring patients to come to the hospital clinic. Another hospital has felt obliged to refuse all cases referred for intramural services. We realize the danger of an expanding case load and of efforts spread too thinly. We consider it imperative, however, in our first year, to do a good job of defining just what services are needed. We prefer also to believe that more staff will be added if the need is demonstrated.

In March, 1942, we were receiving officially the following types of case: new admissions (from outside of Cook County) were referred automatically for histories; all parolees were referred automatically for supervision; and patients were referred by the medical staff for parole arrangements.

Soon, however, the department acquired a reputation for listening to patients. If a patient states a need, even though the statement is dressed in fantastic embroidery, we investigate carefully before we call the entire statement delusional. We have had some interesting experiences.

One blind man had for several years been sending letters out for mailing to Springfield, to the Legal Aid and other agencies. He wanted to go to a home for the blind, and he wanted to prove that he had been defrauded by his former landlady. He had been irritable and unpleasantly insistent. We proved some of his story to be true and secured enough circumstantial evidence to give credence to the remainder. His irritability subsided. He is on a waiting list for a home for the blind and has, in the meantime, been discharged to a county home.

The clothing clerk refers many cases of patients whose relatives or conservators do not supply clothing. Thus far, we have been able to handle most of these over the desk—by verifying assets through letters to the courts, by verifying need through letters to social agencies on whom the relatives are dependent, and by arranging office conferences. The business office refers cases of patients whose relatives have become negligent in supplying funds. Attendants, supervisors, doctors, and nurses pass out bits of information for the social-service department to follow up. A doctor recently stated that the wife of a certain patient was aged and in financial need. He supposed it was scarcely our job, but the patient's worries would greatly decrease if we could do something for the wife. This very definitely is our job.

An attendant told us that a relative had recently brought legal documents in for a patient to sign, whereby the patient was to receive $1,000. We cleared through the courts, and discovered that the patient's estate was worth considerably more and was not being properly looked after.

We now have arranged that all letters from lawyers and courts, and all documents pertaining in any way to legal

matters, shall be referred at once to the social-service department. In all instances, we clear with the courts. Whenever possible, we inform the relative who has, according to the record, been most helpful and devoted. We secure from the court the name and address of the guardian *ad litem* appointed to protect the patient's interest and then write the guardian *ad litem* in order that the hospital's attentiveness shall become a matter of record. These cases are not closed until we are certain that the patient's interests are adequately protected.

We have recently had three different instances in which property belonging to our patients was being sold in other states, and in which the conservators of these patients had not filed reports for a number of years. We have very often found that conservators do not file reports. In these instances, we write a letter to the presiding judge, calling the matter to his attention and asking that the conservator be required to bring his reports up to date. Such accounts are examined.

We have brought to light several rather large estates belonging to patients who have been in the hospital for thirty or forty years or even longer. Progress notes from the medical records clearly indicate that some of these patients could live outside the hospital if they had homes. With knowledge of such estates, placement is not difficult, although relatives and conservators sometimes raise big objections.

It would seem that the present laws regarding the care of the mentally ill were made for conditions of many years ago and are now impracticable. No other public service on so large a scale is given continuously without some attention to a needs basis. Should relatives and conservators have the undisputed right to refuse funds for a patient's removal, even though that patient may have had from twenty to forty years of free hospital care, be ageing, and have assets amounting to $10,000 or even $50,000?

In matters of divorce, we studiously avoid any appearance of taking sides. The courts understand the laws of Illinois, and it is their responsibility to grant or to deny divorce. If a patient later regains sanity, a divorce could then be contested, if the patient so desires. Custody of minor children can likewise be contested at a later date. Adequate support, however, is of more immediate concern.

Recently a sister wished to take a patient home. She gave a convincing story as to why she thought such a plan would be therapeutic. The husband, however, had secured a divorce and, although his salary was $10,000 per year, the court had arranged that since the patient was being cared for in a state hospital, the husband should pay $3.00 per week. Such a decision left the patient at a disadvantage. There were no funds available for her immediate expenses. The sister could not delay for court action. Fortunately, in this instance the sister found funds for the immediate expenses and left the case in the hands of an attorney.

The siblings and the husband of another patient came together to the social-service department several months ago. The husband wanted a divorce and the siblings agreed that he deserved one since for twenty years he had provided for the patient and the children, even though the patient had never been able to be a good wife and mother. They wanted to discuss financial support. We explained that the patient had probably received the maximum benefits from hospital care. Since no relative could assume responsibility for her parole, family care was indicated. For a time, she might perhaps earn nothing; later she could probably earn a small wage. Probable costs were discussed. Later we learned that the divorce had been granted; a fair and adequate settlement had been agreed upon. A conservator was appointed. This patient is now on family care and is making good on a job.

Sometimes patients receive notification of heirship. In one such instance, a Wisconsin court could not settle an estate until our patient had a conservator to act. The only living relative was in another mental hospital. We located an old friend who carried on through the advice of the Legal Aid Society.

In another instance, a patient's sister died in Wyoming. One John Doe had filed petition and letters testamentary. Our records revealed that this same John Doe was the son of our patient; that he had been born in a mental hospital in the East; that he had been known to the juvenile court and had been sentenced to a term at Stateville. Our patient had been state clothed; she had apparently not been visited for a long time. Her residence in Illinois was even questionable. John Doe's ability to act as executor was dubious. In any event,

this one legal notification of the settling of an estate in Wyoming brought forth a number of social-service problems.

We have had several instances in which investigation of reports that such and such a patient thinks she has $5,000 or $50,000 proves that the patient is right. In some cases, the patient has received no spending money. In some instances, it is felt that the pleasanter surroundings of private-sanitarium care would probably be beneficial. In many instances, it is recommended that family care should be tried as a therapeutic measure.

We have asked that all letters from social agencies be referred to the social-service department. This seemed logical since doctors cannot be expected to have specialized knowledge about social agencies. Frequently, the doctors obligingly replied to such letters of inquiry, but neglected to ask for return information that would have been of great value in the social planning for the patient in question. Occasionally a doctor would make demands of an agency that on the surface appeared logical, but that, to one who knew the functions and limitations of that agency, seemed not only absurd, but likely to arouse ill will.

We do not count services of this type statistically unless there are problems involved other than the exchange of information. We have, however, lined up some good friends ready to help patients and their families when release is advised.

Quite recently, we offered to relieve the doctors of answering all inquiries from insurance agencies. We made this offer because we believed that, by concentrating this responsibility, we could work out some very necessary policies. Our records were speckled with brief replies telling insurance companies about our patients. We are not ready to recommend policies, but we outline the following tentative questions: Without knowing the type of policy and the terms thereof, were we not taking a chance that the wording of our replies might act against the rightful interest of our patients? Although the laws of Illinois do not require that information concerning patients be kept confidential, should we not, perhaps, require consent in writing from a legally responsible relative or conservator? And should we not, for the patients' benefit, have in our records as full information as possible regarding their insurance?

We answer dozens of these inquiries from insurance companies. Again, we do not count these replies statistically as social services unless there is some problem that demands follow-up. We give you three examples: Disability benefits on a patient's policy are being paid to a wife, who has been writing our clothing clerk that she has divorced the patient and has no intention of furnishing his clothing.

The state has furnished clothing for another patient whose disability benefits have been sent to his mother in Sweden. The mother had been dead for some months. The insurance company now makes current payments to the patient's conservator and is probably trying to discover who had been cashing the checks sent to the mother.

A last example is that of a patient who seemingly carried heavy insurance in several companies. Inquiry revealed that he also has quite a large estate, which his wife and children are enjoying, although they have been unwilling to make any arrangements for the patient's release even when release was recommended as necessary to the patient's continued well-being.

Cases of course do come direct from relatives. Also, there are calls from plain citizens, who have no direct connection with the hospital. One social worker received a call at her home from a rather remote acquaintance who had a friend who had a son who presented problems—would the social worker help? Another person telephoned that she had a friend who had a father who had been to doctors, but the difficulty had not as yet been successfully diagnosed or treated. She hinted hopefully that another friend had sent a friend to our hospital clinic and had received some excellent help. Whereupon, to her great delight, we immediately offered an appointment.

The state of Illinois does not benefit directly by giving these services. Shall we tell our social-service departments that these are luxury services which we cannot afford in 1943? Perhaps we should. Some of the patients for whom such services have been given are too sick to care. Some may never be well enough to benefit. Thus far these services have quite largely been given on the social workers' overtime. What advantages, then, can be claimed for them?

First and foremost, a doctor who counts his successes by

the number of patients he can remove from the hospital, while leaving some untreated for ring worm, flat feet, undernourishment, and the like, is not such a good doctor. And so with social workers. It is painful to a good social worker to turn her back on an unmet need, even though the only living soul to benefit is too mentally ill to care. She may force herself to ignore the need for a time, but she will not wish to remain in a job where such callous behavior is demanded of her permanently—and we cannot afford to lose good social workers.

Then, too, a good proportion of patients for placements have come to light through these services. The state of Illinois at present allows only $18 per month for board and room on family care. Other resources are essential for patients unable to earn a living. In fact they are necessary, since on the present allotment for family care, practically no plans can be made.

An added reason for giving these services is that if we permit unscrupulous or careless persons to take advantage of, or to neglect, the mentally ill, we are fostering a dangerous and evil attitude, which will spread and has spread as rot spreads through a basket of apples. Neglect of their rights and interests has undoubtedly been followed by neglect of their existence.

It is very true that there are instances in which the insane have been deprived of a part or all of their estates. Be it said in passing that hospital employees also know of innumerable families who have been faithful and devoted to their sick through long, long years of discouragement and who have undergone great deprivations to provide any treatment or advantage that might effect cure. Is not the neglect another symptom of the same lopsided development whereby we have attended well the patient in the hospital, but have neglected all else that pertains to him? A very reputable lawyer recently expressed surprise that we expected him to request a conservator he represented to file an overdue report. He said that he represents other conservators who have not filed, and that the hospital has never before expressed any interest.

In the last eleven months we have had about 275 cases referred for personal service. Of these about 80 are now on our list for placement in family care.

Parole Staff.—Each hospital doubtless has adopted its own method of staffing patients for diagnosis, treatment, and parole. Probably no hospital in the state is altogether pleased with its own particular system.

In an ideal situation, every patient would be presented soon after arrival for diagnosis and a plan for treatment; every six months thereafter that patient would again come for review before the medical staff for further consideration of treatment. In this ideal set-up the social-service department would have a much more complete picture of the resources and attitudes of the patient's relatives, friends, and employers. If and when treatment by parole seemed therapeutically advisable, parole would then be carried out.

At Elgin we call such a consultation the "improvement staff." We have also "diagnostic staff" and "treatment staff" meetings. We tried to approach the ideal by explaining over the hospital radio that any patient who had been at the hospital for six months had the right to ask to go to improvement staff. But we have not been able to renew that statement, for our social-service department is too small to carry out so large a program. Many patients who are well enough to leave cannot return to their families, are not able to support themselves, and have insufficient financial resources. If the medical staff has said that they could be released, but the social-service department has not enough workers to make arrangements for them all, the patients become discouraged.

Because we cannot cover all the work expected of us, we must rely upon the doctors to select wisely those cases for whom pre-paroles are essential and those for whom pre-parole interviews must be made.

RECOMMENDATIONS

Care after hospitalization is an important phase of treatment. Experienced social workers must be encouraged, by reasonable salaries and hours, to accept their responsibilities as a real job rather than as a training period for better jobs. In so far as possible the work should be districted reasonably. At present a worker covers from three to seven counties. An institution as large as the Elgin State Hospital should have a staff of nineteen rather than six social workers.

Let us recommend that one social worker be assigned to

DuPage County, another to Lake County, and so on. Then, when a patient was admitted from DuPage County, the department would make an appointment with the relatives to see Miss X, the social worker covering DuPage County, for a history. Miss X, knowing that part of the responsibility for that patient's treatment rested with her, would begin a study that would not cease when a minimum of data had been recorded. She would plan always toward the end results—the ultimate return of that patient to a reasonably successful adjustment in the community. She would visit that patient from time to time on the ward. When personal services were needed, she would render them. She would establish a long-time working relationship both with patient and with relatives. When in the neighborhood, she could readily call at the home long before the patient's hospitalization ended. Social therapy would be under way well in advance of the patient's return. Preparations would not be hurried and unrealistic.

Miss X would also be well known in the community. In place of discreet and pitying silence, she could encourage a more intelligent and healthy interest in the mentally ill. Belated, harried, last-minute scurrying to find a job for a returning patient could be eliminated. Artificial social life need not be fostered. Instead, there would be a continuing, supportive relationship between patient, family, and community which, by being genuine, would be doubly therapeutic. Routine, meaningless visits by a social worker to parolee and paroler would end.

If a patient needed to be returned for a further period of hospitalization, Miss X would help both family and community to view this return, not as a final discouragement, but as a temporary need, and as an added reason for faith in a program that is not unreasonable and that readily accepts again a major responsibility.

Since Miss X is the hospital representative in DuPage County, she will need to know its industries, its courts, its organized social agencies, the races, wealth, poverty, and cultures of its various peoples. She will know key persons to see among the Mexicans who work as section hands for the railroads; among the Negroes who serve largely as janitors, houseboys, and maids; among the commuters who use the county as "Chicago's bedroom." She will know to whom to

turn when a Christian Scientist has a special problem; when a Polish houseworker needs a home and a job; when an intelligent "reactive depression" patient needs help in building a new world for himself; when a dependent, lonely alcoholic is ready to leave the hospital.

Every time an individual or a community becomes personally and dynamically interested in a patient, the hospital benefits—by the freeing of a bed; by the use of the services of many unpaid community workers who are in a better position to render the specific service needed; by a lessening of the powers of the enemies of mental health—Fear and Ignorance, Poverty and Physical Illness; and by the development of insight and participation. Conversely, every time the hospital paroles a patient into an unprepared enviornment, we lose further the coöperation and enlightenment of that community.

Let us proceed further with our imaginary Miss X and our dream of an adequate social-service staff. Miss X would assume a professional interest in each newly admitted patient, his home, and his community, an interest that would continue in various degrees of activity even after his discharge. She would also survey those patients previously admitted from DuPage County—read their records, visit them on the wards, visit their homes when in the neighborhood, perform the needed personal services. Of necessity she would begin with those patients most nearly ready to leave the hospital and those whose relatives are most inclined to insist that the patient should go home before the doctors consider parole advisable.

Thus she would proceed, eventually including for services those patients who have been in hospital for many years, whose relatives and friends ceased to visit them long ago. Among this group we will find, and have already found, many interesting cases. For years, the hospitals depended entirely upon the interest and coöperation of relatives. If they did not accept responsibility, the patient remained in hospital indefinitely. Many such patients have leveled off and are now quite well enough to leave.

Miss X will not need to go on the radio or to lecture to women's clubs. If she has only one or two counties to serve rather than four or seven, she will know which citizens are

bored with card parties and have time on their hands after their Red Cross knitting is done. Some of these people are capable of sponsoring, and could be persuaded to sponsor, a friendless patient or two. With Miss X helping, this sponsoring could become therapeutic. Successful placement in the comunity would not be the final result; it would be a practical beginning to greater interest and an enlightened sense of the community's responsibility to the mentally ill.

Pre-commitment Services.—We know that we cannot decrease the amount of water in a basin if the amount of water that flows from it is equal to or less than the amount that flows into it. Neither can we reduce our hospital populations without due regard to admissions and intake. Miss X, who is known in DuPage County as a representative of the state hospital, should in time, if she is an experienced social worker, be able to help us to see more clearly just what pre-commitment services the hospital should render. She would become acquainted with the court officials; she should attend hearings as often as possible. The community would with increasing frequency consult her about this child or that adult who is evidencing incipient symptoms or even distressing behavior problems. In similar positions social workers have been looked upon at first as "trouble shooters" and been called upon only when the situation was so far advanced that little preventive work could be done. Very gradually confidence has been inspired and many have learned the wisdom of asking help long before commitment is advisable. Miss X could not possibly give all the services needed, nor should she try to do so. Her desire should be to help the community meet its responsibilities, not to take over those responsibilities. Let us give some illustrations:

A family with an ageing parent find that they can no longer give him care at home; they have not sufficient time and energy for the constant supervision necessary, and the senile changes in the parent have greatly complicated the family living. A carefully selected list of nursing or boarding homes may aid them to solve the problem, to the happiness of all. Several such relatives have already expressed great relief at finding some one who could help them in locating suitable homes.

An old man was recently admitted as a patient. A few months later his wife was likewise committed by the township supervisor. According to the scanty information compiled, one felt that the community had neglected and ignored this old couple except for giving them the dole and noting that they lived a peculiar, secluded existence. Does a good-neighbor policy apply only to Latin Americans?

From another county came a patient who had presumably lived a queer existence for years. His behavior prior to commitment seemed not to have changed. His circumstances had, however. He had inherited some property from which he could realize nothing until a sale could be arranged. The township supervisor declared that this inheritance disqualified him for relief. No other agency would agree to give aid to an individual they felt should receive public relief. They solved the problem with commitment papers!

Medical facilities are quite lacking in many counties. If a tuberculous patient can be declared psychotic, he is committed, even though the major need is medical. Recently a man who had been unable to get treatments for a venereal disease was referred to the hospital for admission. He had been refused treatment in the community on the ground that he had not established local residence. He had worked on local farms. Would it be difficult for a social worker who is accepted in the community to turn this man back to that community for the care he needs? If we are to give adequate treatment for mental illnesses, we will need to resist accepting patients whose primary need is medical by helping communities to realize the necessity of making adequate provisions for medical care.

What about alcoholics? Certainly we waste the taxpayer's money with them. We build them up in hospital, turn them out of doors, and reluctantly take them back to sober up again. No hospital wants to follow such a senseless procedure. There must come a day when the communities and the hospitals will stop feeling frustrated and annoyed about alcoholics and will coöperate with intelligence. Keeping alcoholics in hospitals would not be a solution. Refusing them hospital attention is not the answer. An adequate social-service department could help to stimulate community interest, and with the hospitals consciously leading, advising, helping, the communities could

learn to carry on treatment. Miracles would not result, but with an awakened public interest would come greater insight. Perhaps the medical profession would also make some new discoveries about alcoholics.

There is even pioneer work to be done among fellow social workers. Because mental hospitals have not stressed prevention and rehabilitation, we have encouraged some strange philosophies. Social agencies have declared that they must refuse cases who are not treatable. Now who can say which cases are not treatable? What do they mean? They mean that they have discovered their own limitations; they have only so much money and there are some cases for which they can do little without the advice of psychiatrists. A case of this kind they send to a mental hospital as soon as possible and are annoyed when the hospital returns him to upset the constructive preventive work that they have tried to accomplish with the family.

These are good agencies who have in the past and will continue in the future to do much pioneering. They quite rightly will not be interested again in assuming any responsibility for the psychotic or even the psychoneurotic until we take over the rôle of leadership; until it is clear that we are seriously attempting to help our patients learn to live again out of hospitals; until we prove that we are not sending patients out just to relieve overcrowding; until they are convinced that we have identified ourselves with the communities. An adequate hospital staff of good social workers could soon reassure these good agencies, stimulate their interest, and secure their coöperation. The agencies, in turn, would awaken and stimulate the needed community support.

CONCLUSION

The function of a psychopathic hospital is to treat and restore mental patients. This cannot be adequately accomplished when overcrowding makes it necessary to relegate large numbers of patients to a program of custodial care. Because of the war, we have too few doctors. Because of the war, employers and communities are ready and eager to participate in the rehabilitation of recovering patients. It has always been shortsighted and wasteful to neglect the final steps of treatment—rehabilitation; it would be decidedly

short-sighted now to retain patients in hospital because they have no place to go, or to turn them out to an unprepared environment.

It is a therapeutic and economical necessity that we have, in 1943 and in the future, an adequate staff of social workers.

There are 200 Elgin patients on parole in Cook County, who are not receiving any supervision other than attendance at an understaffed clinic. There are approximately 600 patients at Elgin well enough to be released, who could be supported by funds—funds from their own estates, dependency allotments from the government and from relatives in the armed forces, funds from government contract in the case of veterans of the last war, contributions from relatives, Old Age Assistance, and their own earnings. We have funds for about 150 patients ready to release to-morrow if we had sufficient staff to find homes for them and to supervise them.

We need as a minimum staff for the Elgin State Hospital four more in-zone psychiatric case-workers and eight more for the Cook County area. This would make a total staff of seventeen. A minimum staff for Elgin, according to Federal studies, would be nineteen. We have more than enough work on hand to-day to keep such a staff busy for many months. There are many more patients yet to be referred for services. The expense of such a staff would more than be offset by having patients cared for by private funds. The value, in terms of therapy, could not be estimated.

We can provide such a staff. We can substitute a sound, complete program of treatment that will be less expensive than our present circular program. And we can afford to release our best patient workers. A less well-managed hospital should be our pride if it means that patients who are not good workers are beginning their first step toward rehabilitation under the supervision of hospital employees.

RELIGION AND STATE HOSPITAL

Boston, Massachusetts; Chaplain, Worcester State Hospital, Foxtonough State Hospital, and Walter E. Fernold State School

THREE advantages favor the clergyman who works regularly among the mentally ill in a state hospital. In the first place, he is an ambassador from the vast, interesting world outside; secondly, he is not identified with illness or the daily routine in the mind of the patient; thirdly, and of most value, his work is primarily with groups.

Between the normal congregation that he serves and the state hospital into which he comes as chaplain, the minister recognizes many contrasts. The value of the religious services and the results accomplished are often better measured within the state institution. In the hospital, he has real opportunity for therapy and for independent judgment. He is not hampered by prevailing local church traditions and administrative promotion. Thus, through his work in the hospital, the minister reaches a better understanding of his people and convictions that are of benefit to him in his work in a normal society, especially in time of war.

As chaplain in an institution, the clergyman stands in a favored and unique position. He is a representative of the vast and larger world which the patients look upon with longing. All their hopes and dreams are of returning to that vast world, where again they may exercise their personal freedom.

Perhaps in normal life, free from restraints, the patient might not use his time or freedom to better advantage. Most patients forget that, at home, they moved in a rather limited orbit of narrow horizons. Away from home, and inside the institution, they romanticize home and the freedom of opportunity they had there. Patients express resentment at the organized activities planned for their leisure and recreation at the hospital. The movie shows, the dances, the classes, the entertainments are excellent; still, the patients like to think of the time when they could choose their own movies or theater. Or they want to see other walls, and other faces,

and the chance meeting of an acquaintance upon the streets; they are tired of their present surroundings.

Nor do they welcome the necessary régime of institutional life. Eating at regular hours, all eating the same food, arising and retiring at prescribed hours to which all conform, going en masse to exercise or for group activity, requiring permission to mail a letter or to telephone—in such simple things, the patients feel deprived of their personal liberty and identity. They believe that life outside the hospital means selection of one's food and eating places and companions; liberty they would interpret as going to bed and arising at pleasure, and buying and spending to suit individual taste. Patients exaggerate the casual freedoms of normal society (and, like many people, cannot understand rationing), and they forget the empty and deprived days they found unpleasant at home.

The chaplain is reminder of and link with the home they would have. Because the chaplain does not live at the hospital and does not wear the white uniform of the medical staff, he is representative of the larger and more interesting world beyond the hospital. He speaks of that world, and he is the voice of that noninstitutional life which represents recovery. The mentally ill are very sensitive to voices; some of them, indeed, are suffering from "hearing voices" which are considered part of their illness. Patients enjoy the preacher's Sabbath voice, trained to speak of hope and faith. The chaplain brings the point of view of normal society, presenting them with something new to think about, summoning them to new impressions.

Religious services break the tedium and the monotony of the hospital every day. They vary the daily routine. They uphold the patents by providing wholesome perspective and social approval. The influence of the chaplain is thus very great because he is a tacit reminder of the world that the patients would rejoin.

The mind of the patient does not identify the pastor with illness, and that is the second leverage in the work of the chaplain. He does not establish the hospital routine and schedule. He may persuade the patient to take medicine or treatment; he may urge the family to consent to an operation; but he does not prescribe or give the medicine or treatment.

His work is called "religious services"—not "religiotherapy." And religious services are associated by the patients with the days of youth and hope. Familiar hymns, familiar prayers, all the elements of religious worship, recall the happiest recollections of childhood days, of gladness and religious association under parental and church care. Unhappy and forgotten, bitter experiences of childhood may unconsciously warp the personality. Equally powerful and persistent can be the happy and half-forgotten favorable impressions of childhood. Most of these happy recollections and blurred childish impressions are rooted in religious occasions at home or church or school.

The favorite hymns of long ago and the prayers of youth return to mind—though they were often neglected and forgotten in the years that intervened between childhood and illness in the hospital. They return with a balm of healing and hope.

What are the earliest happy recollections of most people? The anticipation and the busy preparation, the house-cleaning, and the excitement of preparing for a holy day or religious festival are glowingly pictured in memory. Such festivals brought the hope of gifts, the expectation of company, the reunion, with every one dressed in new clothes, the special foods associated with each holy day, and the festive mood. These sacred recollections and stirring sentiments return, after neglect, to the patient and stimulate recovery and desire for restoration.

These memories exist only in connection with sacred seasons and with groups. The chief value of religious work in the hospitals is that it awakens memories and sentiments sacred to the group. The physician is compelled, in treatment, to work with one person at a time. He must work with single, isolated individuals, each off by himself for treatment. The chaplain on the contrary works with groups, though not with crowds. In a group, each person counts and has social relationships; in a crowd, individuality and special cases have to be forgotten. A group can have unity; in order to have discipline, uniformity becomes necessary in the crowd. The group has personality and respects the personality of each person; the "mass mind" compels mass obedience and

mechanical conformity. In the group, many individual differences appear.

Whatever he does, and however he serves, the chaplain is symbol and representative of the group. Even in private consultations, he is a reminder of the group. The approach of the physician to one individual at a time has to be reinforced and supplemented by the clergyman through the group. The approach of the clergyman needs to be strengthened and supplemented by the individual method of treatment.

To the chaplain, patients are not classified as "types" for specialized treatment. Each person who consults the chaplain must be made to feel that he is a human being who must live with others, a person who comes from a home and who needs to feel that he belongs to a group. The counsel that the chaplain gives in private conferences serves people in individual perplexity and spiritual difficulty which have to do with their relationships within groups.

The chaplain does not see each person as "fragmentary," but as a person whose personality develops in his group. Language is one of the strongest bonds of a group. The emotional factors inherent in language have not been fully appreciated. Every family has its own language idiom—terms that represent affection or amusement and that are meaningless to others. Addressing the patient in his mother tongue, with full appreciation of the shadings and undertones, constitutes a strong link of confidence and bond of sympathy between the sick and the chaplain. Addressed in his own language, with which he is most familiar—or which he has resumed after years of lapse—the patient, Yiddish-speaking or French or Italian or Polish or Norwegian or whatever else —is made more comfortable. Moreover, the emotional values of language play their part in the use of sacred languages for part of the religious services—Latin at the Catholic Mass, Hebrew at the Jewish services, and the traditional, mystic words of each denominational group.

Public worship in state hospitals must be shorter than the usual church service. Forty minutes, rarely more, should comprise the worship. This means the elimination of repetitions and of unfamiliar prayers. Three or four well-chosen hymns for congregational song; short Bible lesson, unison

repetition of standard rubrics (the Doxology, the Lord's Prayer, and the Creed among Christians; "Hear O Israel," from Deuteronomy 6, and Kaddish Prayer for the bereaved, among Jewish patients), and a brief talk should constitute the service.

These represent the ritual pattern. Within that framework, however, flexibility and variety are more necessary than in the church congregation. The selection of hymns should often be made by the patients, rather than by announcement of the clergyman. With Jewish patients, the choice of hymns is made from over 100 hymns taught them in the hospital—so that no tune becomes stale. The most important prayers are included, chosen from the themes of the major religious holidays and the church calendar. The talks, in a conversational voice and narrative manner, are limited to six minutes and are upon the intimacies of life—love, friendship, health, loyalty, work, ambition, home, family. Feelings should be addressed rather than the intellect alone.

The participation of patients in the services is very important. They must feel themselves accepted and honored within the group. They derive satisfaction from helping to arrange the altar, serving as ushers, distributing hymnals and prayer books, assisting the clergyman in small tasks that enhance their self-respect through the social approval of the group.

The hospital congregation is more of a unified group than any church congregation. The hospital congregation does not fluctuate greatly in attendance. Week after week, the attendance is fairly consistent and regular; the same people come in about the same numbers each week. Thus, the chaplain is associated with a group of great regularity. Continuous and unbroken exercise of influence is possible to a greater extent than in the usual church, where the constituency within the group may vary markedly from week to week.

Seeing the same people, working with the same group from week to week, the chaplain is better able to measure the results and the effect of his work. Newcomers adapt themselves readily to the group. The chaplain must be more informal than in his own pulpit; he does not stand aloof from the patients on a high pulpit. Every church has members who insist that certain unimportant procedures are traditional

and must be maintained; these the chaplain does not find it incumbent to maintain in the hospital and, therefore, he can be friendlier and closer to his people. The chaplain must be quick to modify or to change his service, according to the mood and the interest of the hospital congregation. His sermon, or brief talk, may be in answer to a question asked by one of the patients.

Because the group changes so little from service to service, the preacher has several weeks in which to prepare the people for the coming of an important religious holy day. His Easter sermon need not be confined to the day of Easter; he should take four or five weeks beforehand to prepare the minds and hearts of the worshipers for Easter. And when he preaches in the hospital, he may make use of the blackboard to guide the comments of the worshipers and to write them for every one to see. Classroom methods can be adapted to hospital preaching with value, serving as reminders of the group connection.

This method of preaching helps the mentally ill to recover their self-respect, to feel that they are considered as intelligent and normal. The share of each person is evident—they have contributed phrases and ideas, which were publicly approved. It gives them a warmer sense of integration into their group and helps them to win standing in a religious society of ancient and honored traditions.

Popular impression holds tenaciously to the idea that the mentally ill have become religious fanatics who in illness cherish the illusion that they are saints or holy persons or Messiahs. This popular impression is without foundation. Most of the patients feel a sting of shame that they are in the hospital. Few of them have the exaggerated notion that they are founders of cults or the embodiment of all holiness. Wherever such symptoms appear—excessive ablutions or other manifestations of fantastic cleanliness, long beards, or the sense of being impelled by a central, powerful, and secret radio station in the clouds—the patient is merely revealing his own insecurity with his former group. He is only dramatizing his fear of lack of acceptance among the group from which he came. Religious mania may mean deep feeling of perplexed responsibility for the protection of one's own group, or failure to be integrated among one's fellows.

This desire to be accepted among a group is so dominant that many patients attend their own services regularly and still insist upon partaking of the worship of other denominations. In this way, they hope to embrace larger groups and be included in a larger whole.

Recently, the patients of one hospital proposed that they have a confirmation service. Those selected took their preparation very seriously. They entered the chapel in a beautiful procession, sang the music, and shared the services. Opportunity was extended the participants to say a few words. The first began: "Let us pray God to bless the doctors and nurses for their thoughtfulness and kindness among the sick." The second offered her prayer: "With appreciation, we think, O God, of the work of attendants and others who do all they can to make the patients comfortable, and do so under small pay and working conditions that are difficult."

These spontaneous and genuine words brought applause from the patients. They were part of the group which paid tribute to those of their group who served them.

Because he represents the group and is a reminder of home, the authority and influence of the chaplain are great. Religious services in the state hospital, or in other large organizations of people away from home, are of considerable influence for good to their people. The worship calms patients in their tensions, reminds them of all that they cherished from the days of youth, establishes a bond of sympathy and fraternity with their group, identifies them with the language they love, and awakens their desire to take a useful place once more among their fellows.

CHRONOPHOBIA: A PRISON NEUROSIS*

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THE most common problem that confronts the psychiatrist and the psychologist in prison is chronophobia—a fear of time. It is a neurotic disorder from which almost all inmates suffer sooner or later, although it is more pronounced in individuals with long sentences. This neurosis, peculiar to prisons even as shell shock was to the army, may be characterized as prison panic. It has never received attention because it has not been diagnosed and treated as a psychoneurosis.

Chronophobia is the counterpart of agoraphobia and claustrophobia. Instead of being thrown into a panic by space, either by its boundlessness or its confining nature, the inmate is afraid of time. Its duration and immensity are terrifying. Time is the inmate's main enemy, his symbol of confinement. Thus both of Kant's intuitions of the mind, time and space, serve as the bases for neuroses; they are not only our ways of *knowing* the world, but also our ways of *fearing* it.

The essence of a man's sentence is time. Inmates are sent to prison for a span of time. They must serve it by the calendar; "the bit," as it is called, cannot be hurried or telescoped; it cannot be bartered or sold; it has no substitute. Time may be a metaphysical substance to the philosopher, a spiritual medium to the poet, the fourth dimension to the theoretical physicist, but to the inmate of a prison it is the only reality and the only certainty. It is life itself.

The state does not specify how one must do one's time; it insists only on the amount to be served. An inmate's sentence is a debt that must be paid with time, his only currency.

* Presented at a fortnightly meeting of the doctors of the New Jersey State Hospital, Trenton, New Jersey, January 19, 1943.

He cannot pay it as he does his gambling debts, with tobacco, coffee, sugar, or with promises and favors.

Inmates all speak of their sentence as time they owe the state. "How much time do you owe?" they ask one another. "How much time do you have in?" They are always "doing time," whether they are working or loafing. Many of them can tell you the remainder of their sentence in months, weeks, or days. It is a calculation in which they all indulge. Timepieces, diaries, and calendars are very popular.

Since chronophobia is a new name for a disorder that has never before been clearly formulated, it can best be understood if we describe the metamorphosis of a "bit." The etiology of chronophobia lies in a transitional state of the sentence, for the realization of the true duration of a sentence does not come immediately. It is only when the novelty has worn off and the uncertainty that surrounds the bit is dispelled that its real length is felt. When the inmate comes to grips with his sentence, prison panic sets in.

The introductory stage of a bit is marked by hope, by uncertainty, and by a studied indifference or a care-free attitude. There is always hope, even after the trial. The defense attorney can still appeal; friends and relatives can intercede with the political powers; there are still writs and applications for clemency. All these give false hopes to the inmate. His trial was a vivid drama marked by color, excitement, glamour—in short, a new adventure. He was the cynosure of gaping eyes and the center of attention in the court room.

His first weeks in prison are also full of activity. He is given an institutional number, clothes, cell, rules; he is fingerprinted, photographed, examined by the doctor, the psychologist, the psychiatrist, interviewed by the principal keeper, the parole board, the chaplain, and so on. He makes new acquaintances, acquires new habits, accustoms himself to the prison regulations and code of ethics. In short, life is eventful, and he gets along famously. He feels that he will take everything serenely in his stride.

Suddenly something happens. It may not come for a month, a year, or even five years. But this period of transition, with its crisis, is certain; he cannot escape it, for it comes to every potential neurotic who goes to prison. The

onset of this disturbance is insidious; it comes without warning and without preparation on his part. His only advice has been, "Take it easy." For the first time he realizes that he has a long bit to do, the duration of which frightens him. Perhaps his family have told him that there is no more hope; money is less plentiful; friends have shrunk to hollow statues; the adventurous aspect of the prison has worn off; and as the wife or girl friend writes less often, he begins to wonder, to suspect.

He is now in a panic and suffers from chronophobia. It usually attacks him while in his cell, but it may come in the mess hall, the showers, anywhere. He fears his enclosure, his incarceration, the confining walls, the restraining bars. But this apparent claustrophobia is only an expression of his panic; it arises from his fear of time, which is represented by the prison.

After the first attack, the inmate begins to suffer from anxiety, restlessness, dissatisfaction. He may now experience insomnia, and complain of numerous ills. He develops stomach trouble, pains in his chest, his back, his head. Attacks of tachycardia, giddiness, and palpitations bother him. He joins the daily sick call and takes copious medication to no avail. The physician tells him that he is shamming, malingering, that he is a hypochondriac, since all his ills are imaginary. This only increases his fear. He becomes alarmed and feels that he will die of neglect. Eventually he is referred to the psychiatrist, who is busy classifying inmates, and he receives the label of neurotic. In reality he is suffering from the *trauma of time.*

If he is a belligerent psychopath, his inability to adjust himself becomes more pronounced. He argues over a game of cards, quarrels with the guards, fights with the inmates, and ends up in the principal keeper's court. He will explain that he was tense and temporarily "blew his top." No harm or offense was meant; he just boiled over inside because of something that he could not describe. Who in prison has not seen men walk out of the mess hall, a classroom, or a job, because of this feeling that resembles claustrophobia? The resourceful men say that they are sick and get themselves excused.

When the intensity of the crisis has passed, which is usually in a few weeks or months, the inmate settles down to do the main part of his bit. The degree to which his prison neurosis has subsided will determine the nature and quality of the rest of his sentence. If it has not abated considerably, he will have sporadic periods of turmoil and disturbance or illnesses that cannot be treated by the physician. Mild relapses are felt by the majority of the men.

The rest of the sentence is now done by the clock and the calendar. The men are phlegmatic, indifferent; they have only shallow interests, and a deadened sense of taste, smell, and visual perception. To all outward appearance, they are automatons. This is as it should be; it permits time to pass more smoothly. It distresses them to look before and after; they must live discreetly in the present, only one day at a time.

Many inmates suffer a mild panic just before they are released. They may become apprehensive during the last stretch; they become unsettled, unsure of themselves. Will they be able to meet people again, to adjust to the outside world? Are their friends true, their cronies accessible, conditions propitious? Above all, are they still potent? The effects of time spent in prison have worn them down, and they wonder whether they have been left unfit, for while they paced their cells and pounded the yard, on the outside time has marched on.

Occasionally an inmate senses the cause of his chronophobia and has sufficient insight to be able to speak of it after the severity of the storm has passed. I quote a part of a story written by an inmate; it was called *Time* and was autobiographical, as most prison stories are.

> "Have you ever felt the weight of time? Thicker than the darkness of night, heavier than the walls of stone. So thick that it could not be cut by light or penetrated by rays of thought.
>
> "I awoke and found that my cell was filled with time. It seemed to have body and weight, it permeated the whole room and oppressed me on all sides. It was like a monster clutching at my throat. My heart beat wildly and I gasped for breath. I was overcome by a nameless fear of something I could not understand. It threw me into a panic.
>
> "My first impulse was to scream for help. I jumped from my cot and asked myself, help from what? Something that did not exist? All that I could think of was TIME.

"I grasped the bars of my cell and shook them frantically, pressing my cheeks between them. The bars were cool and soothing, and soon my fear was quieted. But it never really vanished; it was always with me, sometimes vaguely, sometimes painfully so. Time was my constant companion, more unshakable than my shadow.

"We did the bit together. . . ."

Let us look into the prison record of the author of the story. When I met him, he was in prison for the third time. He had received his first sentence of three-to-six years when he was twenty-three years old. He came from a well-to-do family and had had a high-school education. Both of his parents were college graduates, and in a position to offer him many opportunities. Until he took to forgery, he had always had good jobs. In prison he was diagnosed as normal without any personality defects; he was a model prisoner for the first two years.

His first attack came in his cell while he was writing a letter to his parents. He became panicky and was taken to the hospital and given sedatives. Then he developed hypochondria, which lasted the rest of his bit. He was out of prison three months, during which time he was free from hypochondria.

His second sentence was for ten years. This time his symptoms appeared after two months. He suffered mainly from hysteria. He also had delusions of persecution, which were suspected to be the result of homosexual panic. After five years he was released, and for the next nine months he did not experience any of the symptoms he had had in prison.

The third time he was sentenced, he developed panic as soon as he was committed. His psychiatric classification was "neuropath" (others: "neurotic," "hysterical"); the administrative classification was "psychiatric observation." Every one who examined him during the first year believed that he was suffering from marked personality abnormalities of an hysterical and neurotic nature. He proved to be of superior intelligence, receiving an I.Q. of 117, an achievement grade of 10.2, and 87 on the Stenquist mechanical-aptitude test.

According to his reports to the psychiatrist, he suffered from "monomania, melancholy, panic, hysteria, palpitations." He felt fearful, anxious, insecure, and was helpless when he suffered from these attacks. In broad daylight he

felt that he was falling off of a high building, and he became terrified of being confined in small places. For relief he wrote to a mental-hygiene society for a bulletin on claustrophobia. He was on the sick call so often that he was termed a hypochondriac. A psychiatrist who had him under observation for several months wrote, in summary:

> "We are dealing here with a serious case of neurosis. The inmate has undergone a half-dozen operations, some of which were extremely serious in nature, but he also revealed a multitude of physical complaints which appear to be psychic in origin. For example, he complained of difficulty in passing water, but physicians found that repeated catherizing showed that the request was unnecessary. At times his hands and arms were completely anæsthetized."

For the past six years he has had sporadic attacks. Reflecting upon the first years of his last bit, when he was under observation, he remarked that he could not recall whether the attacks were genuine or shammed; perhaps they were a combination of both. He believes that thinking about his sentence brought on the attacks. He can face anything but the contemplation of the time he must put in.

The following is a milder case. W. had been arrested many times, but usually got his case dismissed, or a suspended sentence on a "fix." He had served several months in county jails and had even received a substantial bit in Texas, which ended in a pardon soon afterward. In New York his luck failed him and he got from five to ten years. The first year in prison, he taught school and did a prodigious amount of work. He wrote fifty units of a salesmanship course, and finished a correspondence course in electrical engineering and another in aviation. Whenever he thought about his case, he reviewed his past to see where he had made a mistake. He was able to account for all twenty-one arrests but this one. W. was a confidence man, with an I.Q. of 128.

After a year he began to wonder how much of his sentence he would have to serve. Because of his ten years of illegal activity, twenty-one separate arrests, the numerous suspended sentences, and other features of his record, he realized that he would have to put in most of his maximum time.

This disturbed him so that he developed insomnia and what he considered stomach ulcers. He did not sleep more than a couple of hours a night and often had attacks of retching, which alarmed him immensely. He gave up his

job, was put on a special diet, and began to worry intensely about his wife's casual letter writing. She was to write to him twice a week or not at all, he insisted; he didn't like this uncertain and occasional writing. This was merely a pretext to brood over, for he had been very promiscuous before incarceration, had been arrested in the company of a woman, and admitted that he was not in love with his wife.

Sometimes some factor or condition will postpone the onset of chronophobia for a long time, as in the following example:

V. was sentenced for from twenty-five years to life for participating in an armed hold-up that ended in murder in his absence. He was indicted for first-degree murder and was advised by his attorney to plead to second-degree murder. On the strength of his attorney's assurance that he would get him released after five years, he consented, much against his will.

For five years V. did a remarkably easy bit. He was quiet, industrious, reticent. He was always employed and never arrested for any infractions of the rules. Both inmates and officers liked him.

One day he developed a cold that he could not shake off. He joined the sick call for three months without getting any relief. His friends recommended him to me because they feared that he had reached the end of his endurance and was about to become psychotic.

He complained to me that he had a head cold and pains in his chest, and that he had lost seventeen pounds in three months. He demanded X-rays of his chest, sputum examination, and so on. He was furious with the prison physicians who had told him that his trouble was all in his mind and that any one with a normal temperature and a clear throat and chest could not have a cold. I noticed that his sniffles and nose blowing as well as his cough were all induced.

Within an hour we were able to get at the heart of his difficulty. During the past five years he had lived as if in a dream. He had been certain that his lawyer would get him released when the five years were up. That had been three months before, and he realized now that his lawyer had lied to him. He was face to face with the fact that he had a sentence of twenty-five years to serve instead of five. It had thrown him into a panic and he had been ill ever since. He

was unable to bear the thought of his long sentence. After our discussion he improved rapidly, and in three days he had almost completely recovered.

P. very likely had all the making of a psychopath before he came to prison, which was at the age of seventeen, but he was diagnosed normal, though emotionally unstable. He was considered friendly, talkative, coöperative; his responses were clear and coherent; and memory and orientation both were intact.

He came to prison with an indeterminate sentence of from ten to twenty years for robbery, and was paroled after serving about seven and a half years. I have no institutional record of his behavior, but from what he has told me, he did not make a good adjustment. After three months in Sing Sing he was transferred because he was a trouble-maker.

His second sentence was for fifteen years. He was talked into participating in a crime and took a passive rôle. His institutional troubles began when he met the parole board and learned that he would have to finish the first sentence before he could start the second. He had been under the impression that when the state had given him his freedom by commutation and compensation for good behavior, he could not be asked to do more time on the first sentence. What the state had given him, he had thought, could not be taken back.

P. now showed all the true psychopathic manifestations, such as restlessness, irritability, constant change of jobs, and getting into difficulty with the officers because of irrational and impulsive action. He was always getting hurt, stepping on nails, bumping into machinery, spraining his back, losing his teeth, running into a baseball bat, and so on. All these accidents were "quite unavoidable." He always had bad luck. He also suffered mild delusions of persecution and had an intense hatred of society. He was transferred to several institutions in the hope of finding him more genial surroundings.

This lasted several years. When the parole board decided that he had done enough time on the first bit and that he could begin his second, most of his trouble vanished. In fact, the board set the beginning of his second sentence in

the past, so that he had served over a year of it before he was informed. P. became a model inmate and has tried to remain so for several years. The crisis was over, and he entered into the main body of his bit.

Recently, however, he learned from his family that he might be released in six months instead of in some six years. They were going to fight the right of the parole board to force him to serve his old sentence. Contemplation of this has made him jittery. In a couple of months he has lost fifteen pounds; he suffers from insomnia, nameless ills, and disturbances; he does not know what to do with himself.

These four cases are typical, and do not lend themselves to an illustration of chronophobia any better than any four neurotic cases chosen at random. Time is real and terrifying to every inmate because it is the master of his life. We who are "world free" manage to harness it to our plans; we have variation and difference, development and progress in our lives. But in institutions one day is like another, its routine is changeless and meaningless; life there consists of motion without purpose, something lost and useless, like the moving of the hands of the clock, without significance.

In attempting to treat chronophobia, the psychiatrist should be given a free rein, so that he can make allowances and provisions that are not usually accorded inmates. He cannot remove the cause of the disturbance, for he cannot alter the sentence. Freedom would bring immediate cure. A change of diet, however, a change of occupation, location, habits, and recreation are useful. A little attention and sympathy are also beneficial.

Then the inmate must be given insight into his problem. He must be made to understand that the basis of his trouble is his reaction to the concept of time. The best attitude for him to take is illustrated in a little story called, I think, *Grandfather's Clock*. The pendulum of a large hall clock one day decided to stop ticking; it had been contemplating the great amount of work it had to do, having to tick to eternity, and felt that the task was more than it could face. Its strike held up the motion of the other parts, and a consultation was held. After much argument, they convinced the pendulum that it should not contemplate eternity, since it did not have to

tick for eternity. All it was asked to do was tick once in one second, which it admitted was not too much to ask. If it did this, time would take care of itself.

This is the best hygienic attitude for the inmate to take.[1] Contemplating a long stretch of time is an evil. The inmate is not asked to serve a ten-year sentence all at once, but merely to put in one day at a time; he has to live only one day in twenty-four hours. Thinking of ten years of durance as a single block of time is a form of self-pity not to be indulged in; it brings on a neurosis. Such synoptic views of time are best left for the philosopher, who wants to see time as a unity.

In helping inmates who suffer from the tension of time, all the officials should coöperate. The guards, for instance, should be instructed in the nature of the symptoms, so that they can detect the approach of a crisis and report it to the psychiatrist. The institutional physicians should be able to observe when an inmate is suffering from chronophobia, and turn him over for psychiatric attention, instead of rebuking him for shamming and hypochondria. As some cases of claustrophobia profit by being transferred from cells to the dormitory, some inmates are relieved by having an indefinite sentence changed to a definite one. Chronophobia is a prison neurosis caused by the very nature of duress. Therefore, it behooves the institution to provide treatment for this disorder.

Although chronophobia is primarily a prison neurosis, being at least most prevalent there, it is possible that a little investigation would show that it occurs also in the army and the navy, in concentration camps, among shipwrecked sailors, and so on. In civilian life the wasted time of the adult and the slow passage of time of children are phenomena well known to the psychiatrist and the psychologist.

The close relationship between space and time should indicate that where there is claustrophobia, there may also be chronophobia. To be locked in a room or caught fast in a cave is a combination of both. The uncertainty as to how

[1] A recent article in the *Reader's Digest*, "Five Short Blocks," by the associate editor of *Redbook*, makes a similar suggestion. A famished immigrant was shocked at the prospect of having to walk sixty blocks for his dinner. But by dividing the distance into small units, he walked the sixty blocks without any difficulty.

long one will remain a prisoner is a part of the basic anxiety. I will give only one example. Recently my wife caught her hand between the sashes of a camp window which she was attempting to open. All during the agonizing experience she had before she fainted was the frightening question: How long would she have to endure the pain? This fear was as real as the thought that she might lose her hand. The latter was a more rational fear, the former more terrifying.

Eventually claustrophobia, agorophobia, and chronophobia may be understood as symptoms of a single neurosis or different aspects of a fundamental, basal phobia, in which case this paper will serve to add another dimension to this neurosis. But until such time chronophobia must be considered and treated as a psychoneurosis, combining some features of neurasthenia and psychasthenia. It is an Occidental neurosis and characteristic of people who take time seriously, especially in prison.

THE ADVISER SYSTEM—PROPHYLACTIC PSYCHIATRY ON A MASS SCALE

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THE Adviser System, initiated in the Tank Destroyer Replacement Training Center, North Camp Hood, Texas, in February, 1943, is prophylactic psychiatry on a mass scale, dealing with individual maladjustment and group morale. Its purpose is to enhance *military efficiency,* and it is grounded in realization of the fact that the removal or reduction of personal problems and group irritations will make for greater resolution, strength, and fighting force. It operates through the chain of command. The advisers are specially selected, specially trained noncommissioned officers who, in close coöperation with the consulting psychiatrist and the commissioned officers, aid in the detection and solution of individual and group problems of the trainees.

Soldiers' Problems and Morale.—The army is not and cannot be sentimentally concerned over the personal happiness of Private A or the emotional turmoil in the life of Private Z; but it is and must be concerned with morale. To achieve the highest level of morale, objectives or goals must be clearly seen and action must be released purposively and dynamically toward their achievement. Anything that hinders the wholehearted pursuit of the war aim becomes a matter of military significance. Every man, no doubt, would admit, theoretically at least, that his personal problems are insignificant when compared to the fate of his country; but the fact remains that a man distraught by pressing personal difficulties *cannot* be his soldier best, and a military unit that is expending energy over group irritations *cannot* be functioning at its highest level of military efficiency.

What actually happens in the army situation? Many men who enter have problems related to their dislocation from civilian routine and to their adjustment to military service. In addition, there are innumerable men who were poorly

adjusted in their previous relatively stable community life and whose induction into the army precipitates a host of personal difficulties of an emotional nature. Some of the problems are easily solved; some are much more difficult, perhaps the most difficult being those that stem from the basic instability of the trainee.

Where can the soldier turn for help? The army provides a method. According to the *Soldier's Handbook,* if a man wishes to see his company commander, all he need do is request permission from the first sergeant. Every company commander, in the interests of his own unit, exerts continual effort to ferret out those cases that need help, but as in any large organization, the plan and ideal are occasionally frustrated. It sounds simple; but in actual working practice it is occasionally difficult and involved. Investigation of several cases of men suffering from severe emotional stresses revealed that they had not sought help through channels, and being shy and reticent, they gave up in either disgust or hopelessness. Any delay in the solution of a problem arouses varying degrees of disgust, despair, or defiance. Curbstone advice adds to the confusion. Moreover, the shy and sensitive man, who is often the one most in need of help, finds it difficult, if not impossible, to expose his personal anxiety to so many different persons, he would rather "suffer in silence." As a consequence, the army also suffers through the decreased efficiency of the soldier, his loss of ability to concentrate, and so on. It is easy for disgruntled, disappointed, or distraught men to assume the attitude of, "To hell with the army! It isn't interested in me; why should I be interested in it?" It is difficult for commanders to appreciate the existence of this spirit when their men parade smartly in review; but if it exists, it is a hindrance in training and a definite danger in combat situation.

Too often the trainees get "the brush off"—evasive, noncommittal answers from noncommissioned officers who are either indifferent or powerless to help in a particular situation. Too often the sergeant, who is responsible for discipline and who has many urgent and time-consuming duties, is brief and brusque in his answers. Too often, conditioned and well-adjusted army men dismiss as trivia the problems that to the raw recruit are of paramount importance. Too

often, in the absence of any easily accessible source of information, fantastic misinformation in the form of wild rumors is spread.

There are countless manifestations of this spirit of disquiet and emotional turmoil over unresolved problems. Some trainees develop neurotic difficulties, and "ride the sick book" to the point of interfering with training; some leave camp without permission and become subject to disciplinary action; some wreak great harm by communicating to others their spirit of indifference or rebellion; some even attempt suicide. Inevitably the morale of the whole group is lowered by the disaffection of its constituent members.

The psychiatrist stationed at a replacement training center is in a difficult position. In the present set-up, about all he can hope to do in a camp of from 6,000 to 15,000 persons is to see the severe neurotic and psychotic patients, for whom relatively little by way of therapy can be done in any army camp. The field in which he can perform his most constructive work—that field of minor maladjustments, the amelioration or removal of which will make it possible for a trainee to become his "soldier best"—is hampered by limitations of time and by the fact that he has no adequate way of coming to know the specific cases that need his attention.

Since the mental hygiene of war is in so many respects different from the mental hygiene of peace;[1] since even

[1] In peace time, mental hygiene concerns itself with the solution of personal problems, the patient being an "end in himself" and his particular adjustment being of paramount importance. Peace-time mental hygiene connotes tolerance, deliberation, self-direction, the moral obligation to do one's own best thinking, the supplanting of hatred and fear with forgiveness and understanding. In peace time men learn a "live and let live" philosophy and discover that the relaxed, though steady pursuance of self-established goals is the way of happiness.

In war time, psychiatry concerns itself with group well-being and efficiency, the individual soldier having his significance in terms of whether he helps or hinders the fighting strength of his unit. Military mental hygiene demands singleness of purpose, the subservience of one's personal inclinations or judgment to that which is ordered, automatic obedience, the unleashing of those emotions which will aid most in exterminating the enemy. In times of war men must learn to kill and kill ruthlessly lest they themselves be destroyed; they must "key" all their force toward the accomplishment of a single objective; they must, temporarily at least, forego their "rights," wishes, or needs as individual men that the long-term goal of winning the war may be accomplished.

"normally" well-adjusted men find difficulty in adjusting themselves to army life; since the discontent, unhappiness, and resentment of maladjusted men is contagious and has a deleterious effect on the morale of the whole group, it becomes a military expedient to devise some system whereby to solve the problems of trainees in order to sustain and elevate the morale so essential for military efficiency. The Adviser System provides one solution to this problem.

The Advisers

To obtain a "worm's eye" view of the problems, personal and general, among enlisted men, one should secure information directly from the men themselves. Obviously, a personal interview with each trainee would be impossible. Even if time limitations did not preclude any such procedure, there would result such a welter of irrelevant and biased detail as to be useless. A more effective technique for obtaining essential information, while at the same time maintaining a very intimate contact with the trainees, is the use of specially selected noncommissioned officers to whom the title of adviser is given. These noncommissioned officers live in the same barracks with the trainees, are associated with them continuously during the entire training period, and consequently know them with a degree of intimacy impossible for the commanding officer to establish.

Selection of Advisers.[1]—When and where there are two barracks per company, two noncommissioned officers are chosen for each company. The sergeant in charge of each of the four platoons in each company selects the two noncommissioned officers who, in his estimation, are best qualified for the rôle of adviser. From the eight men thus chosen, the company commander selects the two who are to serve. The personal file on each adviser is investigated, and those whose scores in the army general-classification test are in group 4 or 5 are generally eliminated. All available sources of information are used in a continuous effort to discover men who are either unfit or particularly qualified.

Qualifications of Advisers.—Advisers are chosen on the

[1] The numbers selected and the methods of selection are flexible. The plan herein outlined is one initiated at North Camp Hood, Texas.

basis of the following qualifications: (1) sufficient army experience so that they "know the ropes"; (2) capacity for "common sense" judgment; (3) interest in the work of advising; (4) maturity, usually found in men somewhat older than the average trainee, that will inspire confidence; and (5) "popularity"—that is, the kind of personality that expresses and readily evokes friendliness.

Tenure of Office.—The tenure of office of the adviser is indefinite. He can at any time be replaced by the company commander, acting with the psychiatrist. Also he can, at any time that he finds the work irksome (or for any other reason), withdraw his services. The understanding is clear that neither his replacement nor his withdrawal will affect the adviser's future progress in the army.

Duties of Adviser.—At an initial lecture given to the advisers by the psychiatrist, a general outline of their duties is formulated. A large part of their work is the giving of advice, information, and general counseling to all trainees who seek their assistance. In emergency situations, the adviser can bring directly to the company commander any problem that he is unable or not empowered to solve. Otherwise, the problem is presented at the regular weekly meeting of the company commander and the advisers. Not only does the adviser seek to help those who come to him, but he is also on the watch for trainees who seem unduly worried, concerned, or upset. He attempts to learn the cause of the emotional disturbance, and to the limits of his power, to help in the situation.

The advisers are impressed with the fact that theirs is the constructive task of utilizing their own knowledge, information, and common sense in helping the confused, troubled, or irritated trainee, and of expediting the process of getting the company commander's attention when such is necessary. In no sense are they to engage in spying, prying, or reporting.

Following this introductory lecture, a bulletin is placed on each bulletin board in the company. The bulletin reads as follows:

POST ON BULLETIN BOARD IN EACH BARRACKS

NOTICE

There are many men who have personal problems and grievances. The Company Commander will do everything possible within the scope of

Army Regulations to help such men; it is his desire and duty to take a personal interest in every man in his company.

Should any man have a personal problem or difficulty or grievance, on which he needs advice or assistance, he is encouraged to obtain permission from the First Sergeant to see the Company Commander.

Some men will frequently prefer to talk to an experienced enlisted man before, or instead of, presenting their troubles to the Company Commander. To make this possible, an experienced man has been carefully selected in this barracks as an ADVISER. He has been selected because of his knowledge of soldiers' problems and his ability to give sound advice; he will be glad to talk to you and take your case to the Company Commander for you if you prefer that to seeing the Company Commander personally. Do not hesitate to see him.

His name is .....

Frequently, men who take the advice of unauthorized persons, take action in violation of Army Regulations, and get into trouble. Do not follow the advice of any one except your Company Commander or your adviser.

.....

.....

Commanding.

Education of Advisers.—Through a series of lectures, the advisers are given information that will enable them to carry out their work in the most advantageous manner. Many specific problems can be solved through the aid of the special-service division in each camp. Accordingly, the head of this division gives a lecture, outlining specifically just what services it can render, and places in the hands of the advisers a mimeographed outline which can be used for future reference.

A lecture is given on the technique of gaining the confidence of the trainees, on the need for sympathetic listening, on the value of encouragement, and on the necessity of holding inviolate any confidential information that is given them.

A series of lectures on mental hygiene is given by the psychiatrist. Obviously, the more readily the advisers can recognize neurotic and psychotic symptoms, the more quickly can men be referred for psychiatric attention. These lectures, couched in simplified, layman's language, teach the advisers to recognize the significance of such things as shy, introvert behavior; excessive fear of jumping off walls in the obstacle course; asocial, seclusive tendencies; and so on.

Operation of the Adviser System

Acquainting Trainees with the Adviser System.—By a variety of methods, the services of the Adviser System are

brought to the attention of the trainees; and these services are kept constantly and easily accessible.

1. When trainees are first assigned to a company, the company commander gives an orientation talk in which stress is placed upon the more specific details involving their immediate future. The function of the Adviser System is brought to their attention.

2. The notice giving the name of the adviser for each company remains permanently on the bulletin board, so that a trainee can always refer to it.

3. The advisers themselves not only await the seeking of their advice, but keep on the watch for distressed or disturbed men and take the initiative in starting conversations and attempting to straighten out difficulties.

4. Other noncommissioned officers may refer a man to the adviser, when for some reason or other they are unable to cope with a particular problem. Many noncommissioned officers are simply not temperamentally so constituted as to be either interested in or adept at handling the personal problems of others and are glad to refer cases to the adviser.

5. Finally, the psychiatrist works in close coöperation with the adviser. Whenever a case is referred to the psychiatrist, he calls the adviser of the patient's company into consultation. In this situation the adviser is an invaluable aid. He can give what amounts to a psychiatric social study of the patient on the basis of his observation of the man's conduct and attitudes in the company. Such information is essential both for diagnosis and for the determination of therapy; and such reports from the advisers enable the psychiatrist to handle far more cases than would be possible if he had himself to seek out all such data. Moreover the adviser is able to do much of the "follow-up" work that is so important for establishing the desired changes. One example will suffice to show how this coöperation between the adviser and the psychiatrist operates:

> Private L was emotionally distressed, cried frequently, and was obviously learning very little in his training. In an interview with him, the psychiatrist learned that this eighteen-year-old soldier was excessively attached to his mother and that he had never before been away from home. Moreover, his mother, who was ill, wrote almost daily, complaining

of her "sufferings" and of her difficulty in adjusting to his absence. In psychotherapy Private L was given insight into the neurotic nature of his relationship to his mother, and suggestions were made for the technique whereby he might adjust himself on a more mature level. A sympathetic, but frank letter was sent to the mother, eliciting and securing her coöperation. The case was discussed with Private L's company adviser who sought out the lad's company and arranged to have him go out with groups to facilitate the "socialization" which was an essential part of the boy's learning the new and emotionally stable attitudes that would enable him to become a "good soldier," as well as a mature man. In other words, the adviser was able to emphasize and "clinch," in daily association, the psychotherapeutic formulations given in the psychiatrist's office.

Establishing Contact Between Adviser and Trainee.—The method of approach whereby the trainee seeks help from the adviser is entirely informal. At any time during training hours or in the barracks, questions may be posed. Often all that is involved is a bit of specific information which can be given as soon as the question is asked. Sometimes a more lengthy discussion is required and it may be necessary to make an appointment for some later and mutually convenient time. Many advisers state that they spend from two to three hours every evening talking with different men. How much of the adviser's time will be so employed will be determined by many factors, not the least important of which is the particular adviser's genuine interest in the men and their problems.

As has been stated previously, the adviser does not always wait to be approached. The very qualities that led to his appointment as an adviser—sympathetic understanding and friendly interest in his associates—make him aware of and sensitive to problems wherever they exist. He often, therefore, takes the initiative and offers his assistance. Some of the most valuable work accomplished by the advisers is along this very line; for often the man most deeply in need of help is by nature so shy or is so overwhelmed by his problem that he is hesitant about speaking of and publicizing his troubles.

The Nature and Solution of Individual Problems

The problems most frequently encountered by trainees fall roughly into three categories: (1) those that have to do with

the minutiæ of army life—*e.g.*, the matters of passes, insurance, furloughs, securing "free" mail, allotments, transfers to other branches of the service, discharge on the basis of being over-age, and so on; (2) personal problems sometimes precipitated and often intensified by entrance into army life—*e.g.*, financial difficulties, dependents, distressing home situations, and so on; and (3) problems arising out of basic personality maladjustment which is aggravated by the stress of army life—*e.g.*, excessive fearfulness, inability to get along with others, uncontrolled temper outbursts, and so forth.

That many of the questions asked seem "silly" to one habituated to army life, or to one accustomed to reading or otherwise finding out answers for himself, does not mean that those very questions are not a source of confusion or disturbance to the uninitiate. Many of these questions the adviser can answer directly from his own knowledge and experience. Similarly, his common-sense advice and judgment are often sufficient to help a troubled trainee work out some less concrete personal problem. These problems vary all the way from not having the price of a hair cut to having had to leave a family heavily encumbered with debt, from being "homesick" to being acutely disturbed over a pregnant girl friend. Sometimes the adviser can offer practical solutions; sometimes the very act of talking out a situation clarifies it for the one burdened, so that he can think out his own solution; and even in those situations in which there seems to be "no solution," the soldier obtains relief just by getting his worry "off his chest."

If the problem is too difficult for the adviser to handle or if other assistance is needed, he then refers the case to the company commander, under whose direct and complete control the Adviser System operates. If the situation is of an emergency nature, the help of the company commander may be sought at any time; otherwise it waits until the weekly meeting, which is arranged at the convenience of the company commander. He may effect a solution of the problem in a variety of ways:

1. He can arrange for the coöperation of the American Red Cross or for the obtaining of funds direct from the Army Emergency Relief Association.
2. He can recommend passes or furloughs.

3. He can arrange for limited service or for transfer to an organization where the man's special abilities will be better employed.

4. He can arrange for dependency or other kind of discharge.

5. He can request a psychiatric consultation. In such a case the adviser fills out the following form:

COMPANY .....
..... TANK DESTROYER TRAINING BATTALION
TANK DESTROYER REPLACEMENT TRAINING CENTER
North Camp Hood, Texas
Date.....

SUBJECT: Request for Psychiatric Examination.
To : Psychiatrist, TDRTC, North Camp Hood, Texas.

1. Request an appointment for the psychiatric examination of:

.....
(Name and Grade) (ASN) (Organization)
for the following reasons:
.....
.....
.....

2. The following is a report of the adjustment he has been making in the organization:

A. Intellectual Ability: (Can he absorb simple instructions, etc.)
.....
.....

B. Physical Coördination and Ability: (Describe and give examples)
.....
.....

C. Attitude: (*e.g.*, coöperative, belligerent, respectful, etc.)
.....
.....

D. Physical Complaints: (heart, legs, head, etc.) .....
.....
.....

E. Social Adjustment: (How does he get along with others? What does he do with his free time? Does he mix easily? etc.) .....
.....
.....

F. Evaluation: (Your opinion as to his retention in service and why).
.....
.....

Signed: .....
.....
.....
Commanding.

6. He can give the trainee practical and specific advice on techniques of handling the problem, and so on.

The special-service division and the consulting psychiatrist can help in the solution of many problems; but it is always in coöperation with the company commander. Much of the success of the Adviser System depends upon the rela-

tionship maintained between the company commander and the advisers. The latter are an invaluable aid both in saving time for the company commander, by dealing directly and conclusively with multitudinous minor problems and by keeping him intimately aware of the "spirit" and morale of his group. The morale of the whole company is greatly elevated by the realization that in their company commander they have an officer who is their friend; and nothing else more quickly establishes that realization than the speedy and fair solution of problems that, through the adviser, are brought to his attention.

Typical Personal Problems.—The following brief "case histories" illustrate not only the variety of problems presented to the adviser, but also the technique of solution that the Adviser System employs:

A soldier who was extremely disturbed emotionally came to his adviser and told him that he was "beside himself" with worry over what he could do about his mother, who was insane. Discussion revealed that the mother had been placed in a state mental institution. After extended discussion between the adviser and the trainee, it became obvious that the best possible solution for the mother was to be in the asylum and that the trainee could in no way aid her. However, because the soldier was not completely satisfied, an interview with the company commander was arranged. Substantially the same suggestions that the adviser had made were given by the company commander. Private A, who was sympathetically treated and who was given an honest evaluation of his problem, was able to make an excellent adjustment instead of having a continuous emotional disturbance that would have impaired his efficiency as a soldier.

Private B, whose wife was due to have a child, requested an emergency furlough; but because of the war situation at the time, the request was denied. This denial was a severe disappointment to the soldier, who began to drink beer at the post exchange to such an extent that he would come to the barracks intoxicated. The adviser undertook to look after him. He talked with him frequently and went along with him on the beer-drinking expeditions. As a result of conversations with the adviser, Private B "woke up" to the futility of his behavior and "snapped out of it." He became personally loyal to the adviser and thereafter made a good adjustment as a soldier. A significant side light in this case is that the adviser, who had previously been regarded as a "hard-boiled old army man," improved tremendously as a result of his advisory experience. He developed greater sympathy and understanding for his platoon and curbed certain bullying tendencies that previously had been pronounced.

Private C, who had been a soldier in the defeated French Army in 1940 and who had been interned in a Nazi concentration camp, felt

qualified for work in the Intelligence Service. He had a continental background and an excellent knowledge of five European languages. He discussed the problem with the adviser, who in turn referred the matter to the company commander. The company commander, in turn, was impressed by the man's qualifications and got in touch with the classification section, which in turn referred the man to the proper authorities. While the exact position assigned to Private C is unknown at the present moment, it is true that he was transferred from this camp under special orders.

A youthful soldier of nineteen was very much disturbed and upset when his girl friend failed to answer his letters. He appealed to his adviser for help. The adviser, who had a lot of common sense, talked to Private D and counseled patience. The soldier continued to be distressed, but having some one whom he trusted to talk to, was able to discharge much of his tension in this way. Fortunately, a few days later Private D's girl friend wrote and thus the problem ended. It is highly probable that Private D, who had entertained thoughts of drastic action such as going A.W.O.L., would have acted on them if he had not had this opportunity to release his tension and obtain advice.

One soldier had a great deal of difficulty in drill, marching, and "doing double-time." Although he had gone on sick call, the initial examination had revealed no outstanding pathology, and the soldier was ordered to return to full duty. The adviser was convinced that Private E was neither neurotic nor malingering and referred the case through the company commander to the psychiatric consultant. The psychiatrist ascertained the fact that Private E had had in childhood a fever that was followed by prolonged weakness of the muscles of the legs. Orthopedic consultation, which was arranged for, established the fact that this boy had suffered from infantile poliomyelitis and reclassification for limited service was arranged.

Quite a number of men who have physical difficulties without gross and easily recognizable pathology are classed as neurotic. This difficulty is the result of a shortage of doctors; for at "sick call," when from 20 to 100 men have to be examined in a short period of time, thorough examinations are impossible. Consequently some men with physical complaints are returned for active duty. The psychiatrist, having more time for each interview, is often able to ascertain evidence that establishes the validity of the physical difficulties.

The adviser referred Private F through the company commander to the psychiatric consultant. Private F had been in the company for ten days and had eaten only two meals during that time. He had not complained and had continued in his regular activities with the other trainees. It was only because the adviser was cognizant of the individual habits of the men in his section that the case was reported. On examination it was found that Private F was suffering from an early schizophrenic psychosis; that he performed his duties mechanically; that he was not interested in food; that he "phantasied" greatly; and that he was suffering from the feeling of persecution. Private F was referred to the neuropsychiatric ward for further study.

Private G received a letter from his wife stating that the doctor had insisted that she be operated upon immediately, that she had no funds, and that under no circumstances would she go to the charity hospital. Private G was frantic; he spoke to the adviser and at once got in contact with the American Red Cross. The American Red Cross wired their worker in the soldier's home town and arranged for the wife to be taken into a government station hospital and even provided temporary financial aid for the soldier's child for the period of the operation. Private G was overwhelmed with gratitude to his adviser for this solution.

Private H, who had been a clerk in a large city and who had come from a rather protected home, reported to his adviser that he was on his second consecutive day of kitchen police. The day stretched from 4:00 A.M. through until 10:00 P.M. The soldier was exhausted and distressed; and then he noticed his name on the bulletin board for the third day of K.P. duty. The adviser was consulted, recognized that there had been an error, and by arrangement with the first sergeant corrected the situation.

The Nature and Solution of General or Morale Problems

Although the Adviser System was initially designed to help meet and solve individual problems and thereby to strengthen the morale of particular soldiers, it soon became apparent that it could and did serve another equally important function. The advisers, who, in addition to attending the training lectures, meet once a month with the psychiatrist for the discussion of problems, began to present situations that were acting as irritants for the trainees in general and that were serving to lower the morale of whole companies or battalions. Of course there are the customary "gripes," common with the American soldier; but in addition there are many remediable conditions that affect the spirit of the whole group in a seriously detrimental fashion and that yet are of such a nature that they never reach the attention of the company or battalion commander. The following instances are illustrative:

One battalion had very poor morale because of the excessive time spent in "detail." In this one battalion, where much work needed to be done, the trainees were called out during their free hours, after their training schedule was finished in the evening, on Saturday afternoons, and even on Sundays. The details involved necessary work, but the difficulty lay in the haphazard way in which men were selected and in the poor organization of this extra work.

In another battalion, according to the adviser, trainees came away from the mess hall hungry most of the time; portions were too small; and the men were not permitted second helpings. It was found that an

adequate quantity of food was sent to the mess hall, but that the mess-hall organization was primarily at fault.

In one company the adviser stated that the men felt extremely depressed because they did not have time during which to write letters—"the lights in the barracks were extinguished at 9:00 P.M., and the men were often occupied up to that time."

In another battalion the advisers told how some trainees had to work long hours on K.P.—not as punishment, but as part of the regular schedule. Some of these men worked sixteen to twenty hours at a stretch, and 50 per cent of these K.P.'s developed blisters from the hot and greasy water. Here again investigation revealed that the morale-breaking situation was the result of an oversight in the mess organization.

Such situations not only provide an unnecessary and excessive stress on emotionally unstable and sensitive men, but they also have a deleterious effect on the general spirit.

To arrange for a solution of such problems, the advisers meet once a month with the battalion commanders, at which time situations involving the whole battalion are presented. The advisers write out their statements on a specially prepared sheet. The battalion commanders realize the importance of this source of information and, in their discussions with the advisers of the specific details involved in each of these complaints, obtain first-hand information on the general morale situation. The battalion commander must avoid the danger of asking for specific names, since the entire value which the adviser has as the confidant of the men will be jeopardized if there is any "reporting" of specific persons. The battalion commander uses this information as a basis for further investigation, determining by other methods the validity or spuriousness of the complaint. Because of the tremendous deference of the noncommissioned officers to battalion commanders, the most common response to his request for trainee problems is, "Everything is fine." As one battalion commander expressed it, "I realized that I had two strikes on me when I went into the meeting." Great care is necessary to keep this channel of information open and flowing freely. It is extremely interesting and revealing to note how during these advisory meetings—which the psychiatrist holds by regiment, there being on an average of 30 advisers to each regiment—the advisers are far more interested in the welfare of the trainees and in the trainees' problems than they are in their own immediate problems. The emotional

rapport that these advisers achieve with their men not only gives them this selfless interest, but actually makes them better cadremen.

The Rôle of the Psychiatrist in the Advisory System

Because of the obvious limitations of time and, far more, because it is important that the company commander retain complete control of his unit, this advisory system has been organized to function through him. However, in this program, the psychiatrist must be the stimulating, coördinating agent as well as the consultant in special problems. It is extremely important that the psychiatrist have direct access to the regimental commanders and to the commander of the entire organization. Problems that involve individual personalities can be handled by the psychiatrist directly; but problems that pertain to general morale and that do not involve specific persons are best dealt with by consultation with the highest authorities involved.

The psychiatrist meets personally and informally with the various battalion commanders and, wherever possible, with the individual company commanders, to discuss the general situation. He arranges for the lectures on mental attitudes and the recognition of neurotic and psychotic symptoms and for the acquainting of the advisers with all new regulations that have a bearing on the trainees' personal problems. In these conferences about morale, a psychiatrist acts purely as a consultant who provides information that violates no confidences. It is important for the psychiatrist, no less than for the adviser, to make certain that he in no way betrays the confidences that he receives.

Not infrequently there is an unevenness in the organization of the Adviser System—"unevenness," in that in some companies the system works superbly, while in others it renders a minimal service. It is here that the psychiatrist needs to inquire into the cause and to provide the stimulus that will bring the condition up to par. There is an occasional company commander who, not understanding that the program is designed to improve the morale and the efficiency of his company, will be negative and apathetic in the carrying out of the program. Where he can, the psychiatrist performs one useful function in formulating the problem correctly and

obtaining the company commander's coöperation. Coöperation is the keynote upon which this whole system is built.

Value of the Adviser System

It is only when enlisted men, advisers, psychiatrist, and commissioned and noncommissioned officers alike have intelligent comprehension of the purpose and value of the Adviser System that it can function at its highest level of efficiency, for such comprehension leads to willing and enthusiastic coöperation.

The program is in no sense one of pampering and coddling. On the contrary, its whole purpose is so to toughen men that they may achieve their highest potential military efficiency. The comment of one sergeant, notorious, incidentally, for his indifference to the personal problems of men in his control—"We do not need advisers here. We've got He men in our company. It's a 'Girl Scout' idea; and anyhow I never heard of it before"—indicates not only that he had no conception of the true nature of the system, but that he was equally oblivious of the fact that men are primarily men and that they can be better soldiers to the degree that they are "whole" and adjusted human beings. The healthier a man is in body, the more quickly can he be toughened physically to endure the inevitable demands that warfare will make upon him. The healthier a man is in spirit, the more adequately can he be toughened psychologically to meet and to overcome the equally inevitable combat claims for resoluteness, courage, and singleness of purpose.

The Adviser System is one means for implementing the democratic ideal that every man has his "rights" as well as his responsibilities; it is based on recognition of the ultimate worth of human personality; and it is an important aid in achieving the individual and group morale so essential to military efficiency and invincibility.

THE UNIQUE STRUCTURE AND FUNCTION OF THE MENTAL-HYGIENE UNIT IN THE ARMY *

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INTRODUCTION

MILITARY life, particularly in time of war, compels every soldier, so recently a civilian, to make difficult readjustments at a tempo and in an environment of authority and discipline that are largely foreign to everyday life. The loss of individuality, the change in the most detailed habits of life, and the hovering imminence of danger and of death inevitably bring about problems. It would be strange if some soldiers did not show their problems of adjustment to this new environment. It is significant that, during the last war, the War Department received the following cablegram in July, 1918, from General John J. Pershing at Chaumont: "Prevalence of mental disorders in replacement troops recently received suggests urgent importance of intensive efforts in eliminating mentally unfit from organization of the new draft prior to departure from the United States."

At the present time, 50 per cent of the Veterans' Administration beds are filled by neuropsychiatric cases from the last World War, and it is estimated that it has cost the United States an average of $30,000 to care for a service-connected neuropsychiatric disability from inception to cure or death. The presence of a psychiatrist within a line organization is one definite way of reducing this high incidence in the army.

* Since this paper was prepared, Brigadier General Edgar L. Clewell, U. S. A., has been transferred and assigned to command the Army Signal Corps Depot at Chicago. He has been succeeded at Fort Monmouth by Colonel Carroll O. Bickelhaupt, S. C., formerly Deputy Signal Officer in the Office of the Chief Signal Officer, Washington, D. C.

On August 10, 1943, the Eastern Signal Corps Replacement Training Center became known as the Eastern Signal Corps Unit Training Center.

The United States Army is doing this job to-day through the use of new specific measures at various stages in the military installations through which soldiers pass as they are molded into a finished, fighting unit.

In general, the demands of military life and training upon the individual's personality make-up are severe. A military mental-hygiene program must be prepared to deal with many different facets of the individual's personality. Fundamental to any such program is the use of the professional skills of the psychiatrist, the psychiatric social worker, and the psychologist, working as a clinical team, under the direction of the psychiatrist.

By the time the inductee passes through the Selective Service board and the induction station and reaches the reception center, it is generally assumed that he has met the basic qualifications for military training. At this point, then, there is a further sifting of the individual's capacities for military service, by the classification and assignment sections, with a neuropsychiatric service available for consultation. This is based upon personal interviews and standardized tests. When the soldier has reached this stage of indoctrination, the assumption is that he will be able to learn a useful military specialty or at least be capable of performing the work of a basic soldier.

There are three major factors to be considered in the formative process of becoming a soldier: physical, intellectual, and emotional qualifications. The first two lend themselves most readily to standardized methods of measurement and analysis. The factor of emotional balance or mental health, however, is often elusive. Since it is qualitative, it is not so readily accessible to measurement. Moreover, what a soldier does with his basic intellectual and physical equipment is always determined by variable emotional factors.

The replacement training center is the earliest proving ground of a soldier's ability. Here his total personality—his emotional, intellectual, and physical qualities—come into contact with the army. In this military installation, such difficulties as may exist generally begin to reveal themselves and come to the attention of the commissioned and noncommissioned officers who are responsible for the training of men. It is with the question of what is to be done with and

about problems presented by the soldier that a mental-hygiene clinic is concerned.

The basic function of the Eastern Signal Corps Replacement Training Center, as of all replacement training centers, is the training of specialized soldiers. To do this, the center must first help the new soldier make the necessary physical and emotional transition and adjustment from civilian to army life, and second, must train him in a Signal Corps specialty, so that, at the termination of his training, he will be capable of joining a regular unit and contributing a technical skill.

Several administrative sections mentioned in this paper are concerned with the processing and training of all men routinely received at the Signal Corps Replacement Training Center. These include the various training schools, the classification section, the personnel section, and other organizations. Such facilities are concerned with processing the average man who comes to the center for training.

Some men have difficulty in one or more areas of army adjustment. These difficulties are particularly observable, for example, in soldiers who are guilty of violations of Articles of War, in soldiers who are failing in the training schools, or in cases of illiteracy. In certain cases, behavior problems of various types exist, sometimes severe enough to make psychiatric hospitalization advisable.

To meet the challenge of the problems of adjustment presented by the men coming to this training center, the commandant, Brigadier General Edgar L. Clewell, established the mental-hygiene unit here over two years ago. The tests of time and experience have proven the effectiveness of the unit's mission and methods of procedure. The basis of the unit's functioning is set forth in the directive promulgated by the commanding general; in it are expressed both content and structure of the unit's responsibilities:

> "1. The mission of the Mental Hygiene Unit is to:
>
> "a. Provide mental-hygiene facilities to E. S. C. R. T. C. organizations and officers and assist them with soldiers who present various forms of maladjustment, as inaptitude, unusual behavior, malingering ('gold-bricking'), recalcitrance, alcoholism, and others.
>
> "b. Institute such corrective measures as are considered appropriate by the director thereof, to reduce or eliminate the individual's maladjustment and eradicate factors related to incipient causes of

mental breakdown to the extent necessary for the soldier to perform military duties.

"c. Determine whether an individual whose case is brought to it for attention is either in an assignment that does not utilize his capacities to the fullest possible extent or is being trained in a skill beyond his capacity.

"d. Recommend for discharge from the service such men who, because of mental or emotional factors, cannot function adequately or who present a hazard to the other men.

"e. Provide psychiatric, psychological, and social data and make recommendation to courts-martial and discharge boards.

"f. Aid soldiers who are discharged from the service to make the transition back to civilian life.

"2. Soldiers in the E. S. C. R. T. C. in whose cases action by the Mental Hygiene Unit appears necessary will be referred thereto by any one of the following:

"a. Staff sections

"b. Personnel and classification officers

"c. School directors

"d. Chaplains

"e. Regimental, battalion or company commanders

"f. Infirmaries and hospital

"g. Inspector and intelligence officer

"h. American Red Cross

"3. Soldiers desiring to consult the Mental Hygiene Unit are to be referred thereto upon request by their company commander.

"4. Immediately upon return to duty, an enlisted man who has been A.W.O.L. for more than 24 hours will be reported to the unit by memorandum, noting the soldier's name, serial number, date of leaving and return, and any other pertinent information.

"5. In all cases where courts-martial charges are filed, the soldier in question will be referred to the unit without delay.

"6. Immediately upon approval by appropriate boards of the discharge of any soldier, his name will be brought to the attention of the director.

"7. In addition to the types of cases referred to in earlier paragraphs, there will be brought to the attention of the director of the unit those men showing indications of illiteracy or mental deficiency either at time of arrival (as indicated by low army scores, behavior during initial classification interview, etc.) or during subsequent training period.

"8. A limited-service board, with the director as president, having been established for the E. S. C. R. T. C., the limited-service status on all soldiers arriving here so classified will be brought to the attention of the director for evaluation, assignment, or reclassification.

"9. The method of referral shall be through written memoranda giving reason for referral and other relevant information. On receipt of such memoranda, the unit will schedule appointments and call in the men concerned. Where expediency is indicated, telephone referrals may be made.

"10. The director of the unit will dispose of the cases referred to him by any one or a combination of the following methods:

"a. Counseling, psychiatric social work, and psychological testing.

"b. Reclassification, where considered advisable.

"e. Special programs coöperatively developed through contact with the sources mentioned in paragraph 5 above.

"d. Special psychiatric treatment.

"In all these categories (a to d inclusive) are included reclassification of all actual or potential school failures due to demonstrated inaptitude, extreme dissatisfaction, or psychological hazards.

"e. Referral for training to the special educational unit.

"f. Extension of training time where such time, lost because of factors beyond the soldier's control, is necessary to complete training.

"g. Referral to American Red Cross.

"h. Psychiatric observation at station hospital.

"i. Recommendation of disposition by a board of officers convened under Section VIII, AR 615-360. (Within this category are soldiers found to be psychopathic individuals, mental defectives, chronic alcoholics, enuretics, drug addicts, etc.)

"11. Cases scheduled for action by boards of officers convened under the provisions of Section II and Section VIII, AR 615-360, will be handled as provided for by pertinent regulations.

"12. Reclassifications will be put into effect by the personnel officer through training-assignment memoranda."

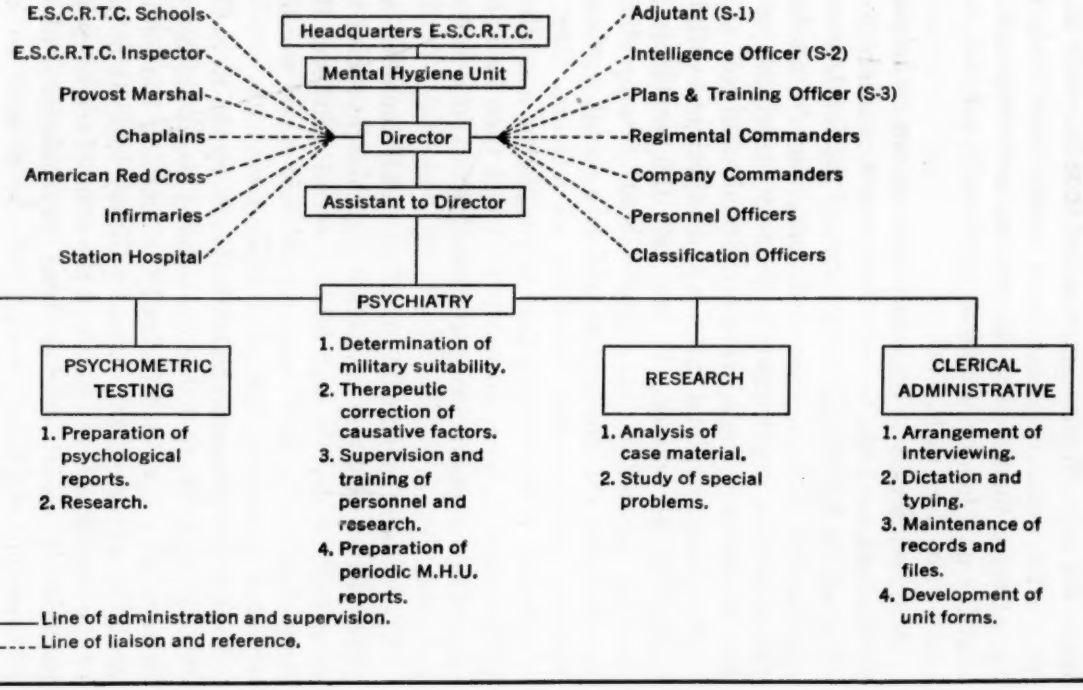
The chart on page 613 shows the organization of the mental-hygiene unit.

Since the problems with which the unit deals involve courts-martial boards, special Section VIII boards, the inspector's office, plans and training, the classification and personnel section, the station hospital, the infirmaries, and most of the other administrative sections, it has been found necessary to set up the unit with its own administrative organization. The psychiatrist, who is the director, is a member of the commanding general's staff, and the unit, as an independent agency, is attached and directly responsible to Headquarters, E. S. C. R. T. C., as has been indicated elsewhere.[1] It functions through the adjutant's office which is the central administrative point of the army organization. This makes it possible for the unit to have direct and effective contact with all the organizational units and resources of the command.

The importance of this administrative structure cannot be too strongly emphasized. It has made directly accessible to the command a resource for dealing with specialized problems

[1] See "The Rôle of the Mental Hygiene Clinic in a Military Training Center," by Major Harry L. Freedman, M. C., (MENTAL HYGIENE, Vol. 27, pp. 83–121, January, 1943.) See also "The Services of the Military Mental Hygiene Unit," by Major Harry L. Freedman, M. C., read at the Ninety-ninth Annual Meeting of the American Psychiatric Association, Detroit, Michigan, May 10, 1943; published in the *American Journal of Psychiatry*. Vol. 100, pp. 34–102, July, 1943.

FUNCTIONAL CHART OF THE MENTAL HYGIENE UNIT
HEADQUARTERS, EASTERN SIGNAL CORPS REPLACEMENT TRAINING CENTER
CAMP CHARLES WOOD, FORT MONMOUTH, RED BANK, NEW JERSEY



that has resulted in the unit's continuing expansion. It has made the unit effective and enabled it to intensify its relationship with other organizational components and, therefore, has affected the scope of the services and determined the rôle that the unit has been able to perform in relation to the mission of the E. S. C. R. T. C.

Some soldiers who present problems can be helped through specialized methods to contribute more constructively to the army and to help fulfill the mission of the Replacement Training Center. Others, even with help, may be unable to meet the minimum requirements of army standards and, in the best interests of the service, must be discharged.

The mental-hygiene unit has had experience with both these categories of trainee. It has met the problems presented through the use of three professional groups—the military psychiatrist, the military psychiatric social worker, and the military psychologist. Working as a team, they make an evaluation of the factors that will influence a soldier's actual performance. Such an evaluation can then be used to help the soldier meet his army responsibilities in a more satisfactory way.

The present organization of the unit includes a military psychiatrist as director, a chief psychiatric social worker as sergeant major, six psychiatric social workers, three psychologists, and a Red Cross psychiatric social worker, who is attached to the unit in a quasi-official capacity.

This paper presents the method used by the E. S. C. R. T. C., Fort Monmouth, New Jersey, to meet the problems presented by men who have had difficulty in meeting the standards set up by army organization and military life. It is illustrative of the significant way in which the clinical team—psychiatrist, psychiatric social worker, and psychologist—placed in a replacement training center, has been able to contribute appreciably to the efficiency of the function of the command. As has been indicated elsewhere,[1] basically, this clinical team can function in any arm, service, or echelon. Its composition is such that the specialists who make up the team are trained in dealing with human behavior, regardless of the

[1] See "Mental Hygiene Clinics in Military Installations," by Major Harry L. Freedman, M. C., in the *Manual of Military Neuropsychiatry*, Topic 39. Philadelphia: W. B. Saunders Company, 1943.

setting. Administratively, there would be the need for relating such a unit to the command in which it is expected to function. This becomes an administrative problem. In civilian life, this has been done, whether the organization was a state hospital, a community agency, a civil or criminal court, a school, a prison, or some other organization.

The body of this paper will deal with the types of problem of army adjustment that come to the attention of the mental-hygiene unit, and will illustrate how it uses its resources to realize the full potentialities of each soldier. The method whereby adjustments are achieved is embodied in the individual sections and case material in the report. Statistics will be added, covering what may be considered an average-year period, in order to give the proper scientific perspective to the mental-hygiene problems and program of a unit in a replacement-training-center installation.

THE CLINICAL TEAM

The immediacy and variety of problems met in a military mental-hygiene unit call for the coördinated use of all the skills of the unit. These are centered in the clinical team of psychiatrist, psychiatric social worker, and psychologist, under the direction of the psychiatrist. The soldier's problem, related as it is to his total personality, is met through the coördination of these skills. No one of the skills can be considered independently of the others in this setting. The particular emphasis and balance of these skills in individual cases grows out of the nature and demands of the specific problem. Intellectual, emotional, and social factors may all require understanding in order to provide adequate criteria for diagnosis, treatment, and disposition. The coördinated skills of the psychiatrist, the psychiatric social worker, and the psychologist, working as a clinical team, is the most efficient approach to the individual soldier's problem. It gears itself naturally to the qualitative and quantitative demands of a military setting. It is obvious that none of these skills is permitted to operate independently of the others. The present section deals with a description of the individual team members as they work together.

The Rôle of the Psychiatrist.—The function of the military

psychiatrist in the mental-hygiene unit is differentiated from that of any civilian psychiatrist by the basic fact of his military rôle. He is a member of the commanding general's staff and acts as consultant to him and his staff on questions of mental hygiene. Therefore, he not only has the purely professional problems of diagnosis, staff coördination, and treatment, but also has a direct administrative responsibility to the command. His fundamental responsibility is the production of adequately trained, competent fighting men, and the mental health of the men in the command, but his discharge of this function must always be determined by the best interests of the army as a whole, rather than by purely individual professional considerations which might apply in civilian practice. It is a basic problem of the mental-hygiene unit continuously to reconcile these two purposes.

The psychiatrist's responsibilities are thus concentrated in two areas: (1) his administrative relationship to the command, and (2) his direct function as a psychiatrist in the mental-hygiene unit. The first relates to his rôle as official representative and channel for the entire unit, its report, diagnostic opinions, and recommendations. The second has to do with the active use of his professional skills in "on-the-job" problems. In this rôle, he coördinates the work of his staff and works with them on each case. When normal problems of adjustment to army living are handled by the psychiatric social worker, the psychiatrist comes into the picture when final action is taken. However, he sees all soldiers processed by the unit in a personal interview. When the problem is one of pathology or of severe emotional disturbances, the psychiatrist will pass professional judgment upon the nature of the soldier's condition. He will indicate the course of action to be followed by the military social worker where the action indicated is the development of a satisfactory program for the soldier.

Where a soldier's problem raises question as to his general suitability, the psychiatrist defines the limits and areas of the soldier's usefulness to the army. If the problem is such that the soldier is amenable to direct psychiatric treatment, and the prognosis for return to full duty is good, the psychiatrist will undertake whatever direct psychiatric treatment may be indicated within the limits set by time and other factors.

In addition to his professional skills, the psychiatrist, as director of the unit, must possess extensive knowledge of the training requirements of the replacement training center's basic and specialist schools or those of the military installation involved. He must also be familiar with the military educational methods and standards of performance of the various categories of personnel. Since the processing of men through the mental-hygiene unit often involves psychological testing, the psychiatrist must have an intimate working knowledge of the use and results of army psychological tests.

In cases where the psychiatrist desires a more specific medical or physical diagnosis or observation on an individual soldier, he makes use of the facilities of the camp infirmary or the station hospital.

It is through this over-all responsibility that the psychiatrist directs and consolidates the various functions of this unit in dealing with the personality of the soldier.

The Military Psychiatric Social Worker [1].—In this report, the term "counseling," equated from a broad point of view with psychotherapy, has been used to indicate a major activity of the unit in helping the soldier with problems of army adjustment. The unit has several specific means for helping the soldier referred to it; these are here called services. As listed in the directive on pages 610–12, a few of these are: classification or reclassification; examination for change of

[1] The military psychiatric social worker is a professional psychiatric social worker who has been trained in an accredited school of social work to understand the nature, varieties, and motivations of human behavior. He participates with the psychiatrist and the psychologist in the diagnosis and treatment of personality and behavior disorders growing out of the individual's impact with conditions of army living and training. Under the supervision of a military psychiatrist, he participates in plans and such measures and treatment as will help the individual make a more adequate adjustment. Through his knowledge and use of military procedures, jobs, training requirements, and army resources, he contributes toward making the most effective use of the abilities of each individual who is having difficulty in making a satisfactory adjustment to army requirements. Through interviews and collateral investigations, he prepares social histories for the use of the psychiatrist. In addition to having the required basic training, the civilian social worker must undergo a three to four weeks' course of indoctrination and training in order to adapt his skills to a military setting. The curriculum includes the following main subjects: General Orientation, Army Administration, Psychiatric Orientation, Medical Social Work, Dynamics of the Psychiatric Case-Work Process, Rôle of the Psychologist, Red Cross Function, Public Relations, Records and Files. It includes also field work and individual supervision, as well as case-work seminars.

assignment and evaluation as related to physical, education, or emotional problems; special-training-unit placement; and submission of opinions to courts-martial boards, commanding officers, and others. This does not imply that there is a service for each problem or even that each problem can be decided by giving to the soldier the means by which he believes his problem can be settled. This is particularly so since it is the army's needs that must always be held as of paramount importance.

The setting in which counseling takes place is the interview. Important in this interview is the fact that the psychiatric social worker himself wears a uniform and represents the army—its requirements and its understanding of the soldier's problem. This is a direct aid to the soldier in helping him establish a relationship with the case-worker and discuss the problem with him. There are many dynamic factors at work in this interviewing situation. To it, the soldier brings his life experience. This includes the way he meets people, his shyness or aggressiveness—in short, everything that makes him a unique and separate personality. It is in the interview with the psychiatric social worker, who represents the army and its demands, that the soldier has an opportunity, as an individual, to come face to face with the forces that are molding him into a soldier. The military social worker, through his understanding of the individual soldier and his problem, as it relates to the army and its requirements, helps him to recognize his army responsibilities. The techniques employed in doing this are the very essence of counseling.

In this counseling process, the soldier has the opportunity to take up his problem and learn whether or not the mental-hygiene unit can help him. Frequently, the soldier does not desire help, but the army requires that some change be effected in his attitude or program because of its needs. For example, where a soldier has a problem and a change in his training assignments is required, he may resist what would be desirable from the standpoint of the army. In such a case, counseling would mean helping the soldier to accept the change and planning with him an alternate assignment that would meet the army's needs as well as help the soldier feel

his continued value to the service. In no way does the unit shelter the soldier from the impact with army standards or requirements. It does, however, attempt to help the soldier recognize their imperative nature without destroying his initiative, self-respect, or basic morale.

It is necessary for the military psychiatric social worker to maintain the thread and purpose of this interview, which always has as its goal a more satisfactory military adjustment. The deepest understanding of human behavior and its complex roots is required to adhere to the twofold purpose of (1) giving the army a better soldier and (2) helping the soldier achieve this either through his own effort or through whatever means are deemed best by the army. The military psychiatric social worker brings to the interview his training in the understanding of behavior, his knowledge of the army and its requirements, and his skill in utilizing the services of the unit as a whole in order to help the soldier.

The psychiatrist is directly involved in the counseling process. He has the responsibility of directing and evaluating all activity between the military social worker and the soldier. When the military social worker and the soldier have thoroughly considered all aspects of the soldier's problem, the psychiatrist is consulted, and it is he who makes the final disposition, basing it upon the general picture presented to him and upon his personal interview with the soldier.

In this report, it will be noted that counseling, as a service in itself, has been differentiated from other services that involve direct administrative action. It is as significant for a soldier to adjust without being reclassified as it is for the unit to facilitate such action for him. There is no lesser degree of assistance in either case. In each, the soldier has gained, through counseling, an understanding of his problem, a consideration of what the unit can and cannot do, and a clearer conception of his position as a soldier. This is the service and function of counseling.

It is in the light of the method described here that all case material should be considered. Examples of case material, for this reason, will show the way in which the unit's help is given. They will outline the source and reason for reference

of the case, the application of the skills of the unit as required by the problem, the evaluation made, and the action taken.

The Psychologist [1].—The functions of the psychologist are basically oriented to the unit's purpose. He, like the other members of the mental-hygiene-unit staff, is, first of all, a soldier, whose primary responsibility is to the army and its objectives. Test results and other psychological data, therefore, are considered for the meaning they have toward the building and maintenance of effective combat forces.

The military psychologist furnishes the psychiatrist and the military psychiatric social worker with data gained from measurements, utilizing intelligence, aptitude, achievement, and educational tests which, combined with pertinent clinical observations, indicate the capacities and abilities a soldier may have. In some cases, a knowledge of the basic personality traits and tendencies of a soldier is obtained through the use of specific personality tests.

Many soldiers whose civilian history and military functioning were in disagreement with their army test score were retested. In some cases, it was found that their original test results had been lowered by special emotional, physical, or educational factors and that the resulting scores did not adequately represent the man's capacities. In other cases, the indicated level of intellectual functioning was correct, but factors—emotional or physical or both—were interfering with the soldier's full utilization of his abilities. In cases of the first type, the reëvaluation frequently resulted in assignment to a school or a job more in keeping with the man's abilities. In the latter cases, these soldiers were referred to the military psychiatric social worker for counseling.

Those soldiers who score in Group V (border-line intelligence) on both the army general-classification test and the

[1] It is understood that a psychologist in this mental-hygiene-clinic setting must have an adequate academic background and clinical experience prior to his entering the army. In order to work effectively within a military mental-hygiene unit, he must undergo special military training to reorient his professional approach to army problems, to become familiar with the administrative set-up of the unit, and to learn to use army channels and resources. Above all, he must be able to relate his findings in functional terms to the other members of the clinical team, the psychiatrist and the military psychiatric social worker.

army non-verbal intelligence test (2abc) are given special consideration. These "slow learners" or "double V" men may possess capacities for routine work or may have compensated so adequately for their intellectual handicap by the development of special skills as to be of genuine service to the army. It is the task of the psychologist to assist in the determination of the degree of their mental development, their learning capacities, and their vocational suitabilities for service in the armed forces. Examination through the use of the Wechsler army intelligence scale is routine for these men and may be augmented by supplementary tests, as each case warrants it.

When mental deficiency is clearly established or no factors to compensate for slow learning ability are evidenced, discharge is recommended. Otherwise, psychometric data are interpreted in terms of possible job assignment within the range of their capacities, as indicated by the test results and their civilian work history.

Aptitude testing in specific areas of skill related to the Signal Corps training program is performed whenever found necessary. The regular army aptitude tests are used and correlated with other psychological data.

A percentage breakdown, covering the period from July 1, 1942, to June 30, 1943, is given in Table I. It shows the great variety of tests used by the psychologist. Statistically speaking, each soldier received an average of three tests. By comparing the number of men tested with the total number of men seen at the unit, we find that roughly one-third of the total cases referred were in need of psychological retesting and rechecking. Educational tests were the ones most extensively used. Of all the men tested, 66.4 per cent had some of these tests. This was due to the fact that the mental-hygiene unit handled all illiterate and non-English-speaking soldiers for assignment to the special-training unit. The army Wechslea intelligence scale was the most frequently employed individual measuring device, having been administered to 48 per cent of all the men tested. The Rorschach ink-blot test ranked highest among the personality tests. It was given to 27.5 per cent of all the men tested.

TABLE I.—PSYCHOLOGICAL TESTS GIVEN AT THE MENTAL-HYGIENE UNIT, JULY 1, 1942, TO JUNE 30, 1943, WITH PERCENTAGE OF MEN RECEIVING EACH.

Individual Tests	*Per cent receiving each test*
Army Wechsler	48.0
Bellevue-Wechsler	3.9
Stanford-Binet	5.4
Arthur point	2.2
Rorschach	27.5
Kent emergency	1.3
Goodenough	37.0
Bender Gestalt test	38.2
Miscellaneous	4.6
Group Tests	
Army general-classification test	4.7
R 1	0.1
Army information (literacy)	42.8
2 abc	27.7
Placement tests (D. S. T.)	66.4
T-M attitude interest	0.1
P-S experience blank	2.8
Reading tests	10.9
Arithmetic tests	6.7
Army clerical aptitude	7.0
Army mechanical aptitude	0.1

The division into individual and group tests is a technical one. With the exception of some army information tests, 2abc, and placement tests, all tests were given individually.

Expediency and practice have led to the development of test patterns. Although such groupings are somewhat crude and subject to frequent changes, the following, to mention a few, have proven to be very helpful when maximum results had to be elicited in a minimum of time:

I. Slow learners, illiterates, and non-English-speaking soldiers	Army information, 2abc, placement series, army Wechsler.
II. Discharge on grounds of illiteracy	Additional Stanford-Binet and educational-achievement tests.
III. Violators of Articles of War	Army Wechsler, Rorschach, Gestalt, Goodenough.
IV. Psychosomatic problems	Rorschach, P-S experience blank, Gestalt, Goodenough.
V. Behavior problems	Rorschach, Gestalt, Goodenough.
VI. Reclassification	Army Wechsler, Rorschach, aptitude tests.

After a man has been tested, the findings are written up in report form. In addition to these reports, conferences with

the psychiatrist or the military psychiatric social worker or both take place for the purpose of discussing the problems presented or the findings obtained. In this manner, full use is made of coöperative clinical teamwork.

Condensed cases, illustrative of some of the psychological problems and services, are appended:

Case 1.—Private P. L., aged twenty-six, was referred to the unit for drunkenness and insubordination and to the psychologist for a check on intellectual status and functioning. He was aggressive, resistive, and negativistic to the testing situation. This attitude was broken down in a series of performance tests in which he was successful, somewhat to his own surprise. He completed the test in a coöperative, friendly manner. Test results indicated high-average rather than below-average intelligence in an individual greatly in need of reassurance and initial success. He returned to the military psychiatric social worker ready to accept help, with a newly discovered confidence in himself and his ability to succeed. Previously unsatisfactory in school, dissatisfied with the army, he finished Cook School with a 98 per cent and looked forward to his shipment.

Tests used: army Wechsler scale, McFarland-Seitz psychosomatic inventory, Wechsler occupational scale.

Case 2.—Private W. S., aged eighteen, was referred to the unit as "mentally defective" and was interviewed by the psychologist for testing. Upon psychological examination, test patterns were found to be definitely not those of a mental defective, but the soldier's performance was so atypical as to merit further investigation. He was seen by the psychiatrist and discharged from the army as an epileptic.

Tests used: Wechsler-Bellevue scale, Rorschach ink-blot test, memory for designs, Stanford-Binet vocabulary, Gestalt drawings.

Case 3.—Private D. O., aged twenty-four, was referred as "depressed and nervous." He appeared more intelligent than his A. G. C. T. score of 99, Group III (average intelligence) indicated. A careful check-up placed his intelligence in Group I (superior). The personality test uncovered areas of conflict in this very gifted, artistic, creative person who had failed to make proper adjustments to routine army life. With these clues to his problems, several more contacts in the unit enabled the soldier to accept his present situation. His school work picked up and made possible a transfer to a more highly concentrated training program.

Tests used: A. G. C. T. (retake), army Wechsler, Rorschach ink-blot test.

ANALYSIS OF CASE LOAD

In considering the case load, emphasis must be placed on variable factors, such as new directives, changes in administrative structure, and the increased acceptance of the unit by the line officer, who has found assistance in its services. It is further evidence of the command's understanding of the

ready flexibility in the function of the unit in dealing with special personality problems which have increased the scope of the unit's work.

A percentage analysis of the unit's case load from January 1, 1942, to June 30, 1943, by six-month periods, shows the following distribution:

	New cases	*Follow-up investigations*	*Total interviews*
Jan. 1–June 30, 1942	15.8	17.7	17.2
July 1–Dec. 31, 1942	26.1	36.3	33.6
Jan. 1–June 30, 1943	58.1	46.0	49.2
	100.0	100.0	100.0

These percentages include a number of interviews within the unit at each new reference or visit, during which the soldier may be seen by one or more of the members of the clinical team.

As is indicated, there has been a constant increase in the volume both of new cases and of follow-up interviews during each of the three periods. In the first six months, during which the unit was defining its initial functions and building its organization, 15.8 per cent of the total case load was processed. The second six-month periods shows a steady and perceptible increase, new cases totaling 26.1 per cent. Toward the latter part of this period, there was an appreciable increase due to an increased responsibility delegated to the unit by the command in maintaining continued responsibility for illiterate and non-English soldiers and soldiers of limited service. Although the volume of illiterate and non-English cases dropped off during the third period, 58.1 per cent of the total unit case load was processed.

Table II is a qualitative analysis of the types of case referred to the unit during the period covered herein. Here again it is apparent that the case load has shifted with the changing needs of the command in meeting new problems. Thus, "limited service," which comprises 39 per cent of the case load during the third period and does not appear as a category during the first two periods, makes up 22.7 per cent of the total number of cases seen at the unit. In like manner, illiterate and non-English-speaking cases comprise, respectively, .3 per cent, 18.5 per cent, and 7.4 per cent of the

total case load of each period and 9.2 per cent of the total cases referred.

TABLE II.—PERCENTAGE ANALYSIS OF PROBLEMS AS REFERRED TO THE MENTAL-HYGIENE UNIT, JAN. 1, 1942, TO JUNE 30, 1943, BY SIX-MONTH PERIODS

	Per cent of cases referred			
	Period I, Jan. 1–June 30, 1942	Period II, July 1–Dec. 31, 1942	Period III, Jan. 1–June 30, 1943	Total period, Jan. 1, 1942–June 30, 1943
Problem as referred				
Courts-martial cases	15.4	28.9	6.8	13.8
Peculiar behavior and emotional problems	21.7	34.9	10.4	18.8
Reclassification	42.9	4.0	3.2	9.6
Illiterate and non-English-speaking	0.3	18.5	7.4	9.2
Psychosomatic and somatic	16.2	11.0	30.2	22.9
Limited service	....	....	39.0	22.7
Miscellaneous problems	3.5	2.7	3.0	3.0
	100.0	100.0	100.0	100.0
Per cent of total *	15.6	26.0	58.4	100.0

* This total includes cases referred for more than one reason.

Reclassification and violations of Articles of War have become a relatively less pronounced problem as the emphasis in function has shifted. As liaison with the infirmaries and hospital strengthened and the unit's function increased in relation to army regulations concerning the limited-service soldier, the percentage of psychosomatic and somatic cases proportionately increased. During the third six-month period this group made up 30.2 per cent of the cases referred. Many of this number were the result of a reallocation and redistribution of cadre personnel as the result of a directive.

It should be noted that as directives were promulgated, they affected the method of and the responsibility for reference of cases to the unit. Since the administrative line of the unit is through the adjutant's office, such changes did not affect the quality and nature of the service that the unit was able to render the command.

Many methods for the disposition of cases have been utilized. In each case, several actions were usually taken, these

being determined by the needs of the particular situation. As a method described later in this paper, counseling was an integral part of each contact, regardless of the reason for which the soldier may have been referred. Counseling was very often the only disposition when it served the purpose of reorienting the soldier's attitude and understanding of his problem. Where there were follow-up interviews, counseling was the method used to maintain a continuing help to the soldier.

Among the other specific dispositions of cases handled by the mental-hygiene unit were those of opinion rendered, reference to hospital for somatic and psychosomatic disorders, reclassification, assignment to a job, discharge of cases, and reference to the Red Cross. Several of these categories are discussed in detail later. It is important to note that frequently several dispositions were used in one case, such as reclassification after reference of the case to a hospital, and counseling that helped the soldier to arrive at a level of adjustment at which he was able to go on toward a more satisfactory military service.

Requirements of the command have demanded changes of the unit. The disposition of cases has changed from time to time to meet the particular problems at hand. In each case, an effort was made to select and to work out with the soldier in the interview the most satisfactory disposition possible. The procedure of continuing contact in cases where dispositions of one type or another were made enabled the unit to carry its responsibility for actions taken to the point where the evaluation of the man's adjustment could be continuous, and where he could also be helped through counseling to make the best use of the action taken toward meeting his problem. The types of disposition and action taken are specifically geared in this replacement training center. Thus, many related to school changes and assignments. Others, such as reference to hospital, opinions rendered, and reference to the Red Cross, represent ways in which the soldier's basic problems to military adjustment are met.

Since all cases handled by the mental-hygiene unit are referred for some specific problem, no case is closed before some definite action has been taken. This action is always

based upon a consideration as to whether or not the soldier can make an adjustment to the army and how he can best be helped to do this.

SERVICES

As the clinical team meets the problems referred to the unit, it utilizes, in their solution, all the resources available in the military setting. These resources include the training school, the company commander, the special-training unit, the classification and personnel section, the infirmary, the hospital, the special-services officer, Army Emergency Relief, the American Red Cross, the Army Institute, and the United Service organizations in neighboring towns.

A large part of the treatment consists of meeting shortcomings and needs with these military resources through modification in the soldier's training program or, in extreme instances, through discharge. As a result of its experience, the unit has found it necessary to have a precise and thorough knowledge of all the resources and procedures in the E. S. C. R. T. C., and to use them selectively and economically. The unit acts in liaison with all the branches of the replacement training center and is thus enabled to assume responsibility for referring a soldier from one section to another until final disposition is made.

The use of any resource or procedure is selective and individual. In some cases, the particular action is demanded by reason of the unit's service to the army. Illustrations of such cases are the reference of illiterate and non-English-speaking soldiers to the special-training unit, and of the mentally ill to the hospital for observation and discharge. In other cases, it may involve a personality evaluation of violators of Articles of War for courts-martial boards or the recommendation of the inapt and the morally irresponsible to the adjutant for discharge via pertinent regulations.

In other situations, resources within the army are brought to the attention of the soldier and the decision as to whether or not he will use them rests solely with him. This type of reference involves a discussion with the soldier of the advisability of going to Army Emergency Relief, the company commander, the chaplain, the special-services officer, or the

American Red Cross. For each case, the particular service or combination of services may be different. While these services are used together as part of the unit's approach in meeting the problem, they are discussed separately for the sake of clarity. The services rendered by the individual members of the clinical team have been discussed in the previous section. Those services in which the unit as a whole participates will be discussed here.

Opinions Rendered (Evaluations).—There are many varied types of problem presented by individual soldiers that require decisions by such authorities as the company commander, the inspector's office, the courts-martial board, the intelligence officer, the adjutant, and others. Where any of the above officers is faced with a decision regarding a soldier in difficulty, it is often of value, for an adequate disposition of the case, to have fuller knowledge of his personality.

The mental-hygiene unit has facilities for obtaining such a comprehensive picture of a soldier's personality. The skills used are the medical, diagnostic services of the psychiatrist; the presentation of the social factors in behavior patterns, the function of the military social worker; and the psychological testing of training potentialities, the contribution of the psychologist. When the director of the unit acts as a consultant on a case, such action is but part of the functions of the mental-hygiene-unit program.

When a soldier is interviewed, on the basis of this type of specific request or consultation, the army's needs receive primary consideration. It is often possible, however, through skillful interviewing, for the soldier to get some help out of such a discussion.

In addition to the directly stated request for an opinion, it is accepted as a matter of unit policy that all reports from the unit express an evaluation that will be useful as a guide for the officer who has brought the soldier to the unit's attention. The following case indicates how the unit's skills are combined in rendering an opinion:

Case 4.—Private T. W., having deserted for the second time after being punished with five months' confinement for his first offense, was referred to the unit for an opinion as to his military suitability. The steps taken by the unit in answering this question were as follows:

A complete history of his military adjustment, as well as a general picture of his civilian adjustment, was taken by the military social worker. Herein, all indications that focused upon the soldier's most typical behavior conclusively established the existence of an inferior personality make-up. The psychologist, through various diagnostic tests, corroborated the soldier's deterioration in the intellectual sphere. The Red Cross, through liaison with the soldier's home and community life, provided a history of long-standing and progressive maladjustment, marked by chronic alcoholism. No organic basis for this behavior was found on medical examination. At the time of the soldier's first offense, the unit had not yet been established. After psychiatric examination by the director, the opinion was given that this soldier showed no potentiality for military service. On this basis, discharge via Section VIII was recommended and effected.

Assignment.—As discussed here, assignment refers only to those cases in which a change in training program was considered an essential part of the plan of treatment. About 12 per cent of the cases referred to the unit were reclassified to other training assignments. There are four types of assignment that have been utilized by the mental-hygiene unit in that manner. In the first, a change is made from one training school to another, either on the basis of the soldier's demonstrated inaptitude in the first or because he shows particular aptitude for the second. Secondly, in some cases, the situation is such as to require a removal from one school and an assignment to basic, non-specialized category because of lack of aptitude or a demonstrated inability to learn in any of the schools. The third type of assignment used in a few special cases has to do with placement in an actual job as part of the permanent cadre of the post. This method is used chiefly with men, limited either physically or mentally, for whom it is felt that shipment into combat duty or even to another post would nullify their value to the service. A fourth group of assignments involves the reporting of a soldier to the adjutant general's office because he possesses specific skill which, though not applicable to the Signal Corps, may be of value to some other branch of service. In working with such problems of assignment, it is essential for the unit to be thoroughly familiar with the requirements of the service—in this instance the Signal Corps—the schools within it, specialized tests and measurements, and civilian occupations. The same principle applies to any installation where a mental-hygiene service is available.

When the soldier is referred to the unit for reassignment, or for other reasons where reassignment may be indicated, careful evaluation of the man's skills and capacities is made. Where necessary, individual intelligence and aptitude tests are administered. The test results and evaluations are then related to the requirements of the training schools. The soldier, through counseling, is given the opportunity to participate in the decision regarding the final choice of assignment. The responsibility for reassignment is shared by the unit, the school involved, and the soldier. In many cases, carefully considered reassignment, in which the soldier carries some responsibility, serves to avert emotional disturbance, which would otherwise reduce his efficiency.

Significant is the fact that of the men referred for violations of the Articles of War, only 21.8 per cent were reclassified to a new school, indicating that the problem was usually related to causes within the soldier's personality. Similarly, many men referred for reclassification were not reclassified. This fact points to the existence of other than real school problems, which may be the symptomatic picture at the time the man was referred. This comparison holds for the other categories as well.

The following case illustrates the method of assignment as it fits into the unit approach:

Case 5.—Private F. M., a twenty-four-year-old soldier of average intelligence and eighth-grade education, who had been a cow-puncher in civilian life, was referred to the mental-hygiene unit after a long hospitalization because he had been placed in limited service due to a knee injury acquired while in action in the Philippines. He was disturbed over his physical condition and inclined to put all the responsibility for it upon the army. With some encouragement, however, he could take part in the task of locating a job placement for him in which, despite his disability, he could function usefully. As the interviewer considered with him how his experience might be used in the army, he brought out an interest in horses and skills in harness work. The unit then got into contact with the officer in charge of the post stables and arranged an interview. The soldier, at first frightened by the prospect of the interview, was given encouragement by the interviewer. After the interview, he was accepted for assignment to the stables. The worker saw the soldier periodically and helped him with his problem of getting back to a definite job after a long period of disability. His knowledge of horses and harness work gained him recognition on the job and advancement to the rank of technician, fifth grade.

Discharge.—Where such large numbers of human beings are involved, as in the strenuous task of war, there will be soldiers who, because of physical, intellectual, or emotional factors, cannot meet the minimum requirements of army standards and who, for the interest of the service, will be discharged. The continued presence in the armed forces of these men would have serious implications for the total efficiency of the army in terms of morale, man hours lost, and hazards to the other men. This relates particularly to the problem of the line officer and the men in training and combat units.

In handling these problems in the Signal Corps Replacement Training Center, the mental-hygiene unit has been called upon to study, evaluate, and recommend the discharge of such men by pertinent regulations. Included among such men are those dischargeable under Section II, AR 615-360, who have certain disorders, such as psychoses, psychoneuroses, epilepsy, and cases of neurological and physical disability. Under Section VIII, AR 615-360, provision is made for the discharge of men who, because of inaptness and undesirable habits or traits of character, are unable to perform satisfactorily in military service. This group includes psychopathic individuals, mental defectives, chronic alcoholics, and enuretics. In WD Circular 395, December 5, 1942, provision is made for the discharge under Section X of those men who, classified as limited service for mental or physical reasons, lack a specific civilian vocational skill, the capacity to learn a military skill, and the ability to perform manual labor day after day. In several instances, soldiers who had been found guilty of serious offenses, such as desertion, statutory rape, and fraudulent enlistment, were discharged under Sections III, VI, VII, and IX.

Of the total number of cases seen at the mental-hygiene unit during the eighteen months from January 1, 1942, to June 30, 1943, 13.4 per cent were ultimately discharged. A percentage analysis of these discharges, classified according to reason for discharge, is shown in Table III. Of these men, 68.6 per cent were discharged via Section II (Certificate of Disability Discharge); 18.8 per cent via Section III; 11.8 per cent via Section X; and .8 per cent via Sections III, VI, VII, and IX. During the last six months of the period covered by

this study, the total number of discharges amounted to 16.3 per cent of the total number seen, as compared with 10.2 per cent during the previous six months, and 7.1 per cent during the first six months. Thus, it is seen that the percentage of cases discharged increased from period to period. This increase is related to the larger number of cases discharged because of physical disability and psychoneurosis. The rise in the latter category is a result, in part, of a change in the army's policy. While formerly mild cases of psychoneurosis were placed in limited service, the present policy is to discharge all men found to be psychoneurotic.

From the report thus far, it is apparent that various manifestations of emotional and mental disturbances occur at different stages of military training. Thus, some soldiers may be referred to the mental-hygiene unit with noticeable symptoms at various stages of psychological breakdown. These cases will include the severely psychoneurotic and psychotic soldiers, who are then referred to the hospital for discharge under Section II, (CDD), AR 615-360. Others may present less severe symptoms. The so-called "marginal" soldier, who has been able to get along with many family and social supports in civilian life, when inducted into the army, may begin to show signs of emotional breakdown, which come to the attention of the unit.

TABLE III.—PERCENTAGE ANALYSIS OF CASES DISCHARGED UNDER AR 615-630, JANUARY 1, 1942–JUNE 30, 1943

	Per cent of cases discharged			
	Period I, Jan. 1–June 30, 1942	Period II, July 1–Dec. 31, 1942	Period III, Jan. 1–June 30, 1943	Total period, Jan. 1, 1942–June 30, 1943
Section II				
Neuropsychiatric:				
Psychoses:				
Schizophrenia	1.4	3.8	0.6	
Manic-depressive	0.8	0.2	0.6	
Other types	1.2	1.0	2.4	
Total	3.4	5.0	3.6	12.0
Epilepsy	...	1.0	1.0	2.0
Neurological disorders	0.2	0.4	2.8	3.4

TABLE III—*Continued*

Per cent of cases discharged

	Period I, Jan. 1–June 30, 1942	Period II, July 1–Dec. 31, 1942	Period III, Jan. 1–June 30, 1943	Total period, Jan. 1, 1942–June 30, 1943	
Psychoneuroses:					
Anxiety states	...	0.6	15.8		
Mixed types	1.0	0.2	1.6		
Other types	0.2	0.6	1.6		
Unclassified types	0.4	0.8	3.6		
Total	1.6	2.2	22.6	26.4	
Total neuropsychiatric					43.8
Physical (asthma, migraine, hypertension, etc.)	0.4	3.7	20.7		24.8
Total under Section II					68.6
Section VIII					
Psychopathic personality:					
Chronic alcoholism	0.6	1.0	2.2		
Homosexuality	...	0.6	1.0		
Other types	1.6	1.4	1.0		
Total	2.2	3.0	4.2	9.4	
Enuresis	...	1.4	3.6	5.0	
Mental deficiency	0.6	1.0	0.8	2.4	
Inaptitude (illiteracy)	...	...	2.0	2.0	
Total under Section VIII					18.8
Section III.—Psychopathic personality	...	0.2	...		0.2
Section VI.—Psychopathic personality	...	0.2	...		0.2
Section VIII.—Psychopathic personality	...	...	0.2		0.2
Section IX.—Psychopathic personality	...	...	0.2		0.2
Section X. (Circular 395)					
Limited service (physical):					
With illiteracy	...	0.6	5.2		
With intellectual defect	...	1.2	2.6		
Total	...	1.8	7.8	9.6	
Limited service (psychoneurosis):					
With illiteracy	...	...	1.4		
With intellectual defect	...	...	0.8		
Total	...	...	2.2	2.2	
Total under Section X					11.8
Per cent of grand total	8.4	19.9	71.7		100.0

The criteria for discharge, in any instance, is the degree of usefulness of the soldier to the army. Evaluation of his usefulness is based upon an intensive study of his personality and history by psychiatrist, military psychiatric social worker, and psychologist. Through selective placement, where this is indicated, an attempt is made to make the fullest possible use of this soldier. Sometimes men can be placed where their limitations do not interfere with their performance of military duties. Discharge is finally initiated where the soldier unquestionably shows no possibility of developing any usefulness to the service.

Literature regarding neuropsychiatric war casualties emphasizes the monetary cost of such cases and their after-care. Of the total number discharged during the period under study, 75.2 per cent were discharged because of neuropsychiatric reasons (see Table III). The financial saving that results from discharge of such cases is self-evident, in addition to the prevention of more endangering breakdowns.

What appears more important in time of war, however, is the effect that these individual cases of deviated behavior might have on the morale and efficient function of the combat team if they had not been early detected. This effect cannot be so easily measured. From the point of view of monetary expenditure, army efficiency, success in war, and conservation of resources, it is important to remove such men from the forces and return them to the community while they are still in a condition to contribute to the war as civilians.

The following cases are illustrative of the situations in which discharge was recommended by the unit.

Case 6.—Private L. S., a twenty-one-year-old soldier of average intelligence, was sent to the unit for study by his company commander. He had just arrived at the E. S. C. R. T. C. for basic training, had been missing formations, and was seen wandering about aimlessly. Interviewed by the military psychiatric social worker, he expressed unusual fear of injury and death. He was preoccupied and confused. It was learned that he had been a behavior problem in school and was known to a psychiatric clinic in the community. Psychological examination at the unit showed marked personality disturbances and deterioration of performance. The soldier's father and brother were patients in mental hospitals. After examination by the director of the unit, the soldier was diagnosed as dementia praecox, paranoid, and discharged under the provisions of Section II, AR 615–360. A Red Cross report revealed a history of odd, withdrawn behavior, which was noted as indicating major behavior trends that could lead to serious mental illness.

This case illustrates the diagnostic service of the unit in assuming the responsibility for removing a soldier from his company.

Case 7.—Private L. M. was referred to the unit for evaluation and recommendation in regard to his having been A.W.O.L. At the unit, the social worker learned from him that he had been to the city, had drunk excessively, and could not regain control of himself until after he had been A.W.O.L. for several days. He had been drinking heavily for the last four years and had several times been on the verge of delirium tremens. Field investigation indicated that the soldier had been making an adequate adjustment in his company, except for his A.W.O.L. incident, and was qualifying in the specialized school that he was attending. Psychological examination indicated that he had sufficient capacity to qualify as a skilled technician, if he could concentrate on his training. Further investigation of his home background was initiated. A report of his civilian adjustment was received from the Red Cross, which verified his losing jobs frequently and being hospitalized numerous times because of alcoholism. This report, taken together with the fact that the soldier had again gone A.W.O.L., made it clear that he could not be relied upon to control his habitual drinking for more than short periods of time. He was recommended for discharge via Section VIII because of chronic alcoholism, and such action was effected.

Case 8.—Private J. N. was referred to the mental-hygiene unit by the classification officer with the comment that "he can barely write his own name, has considerable difficulty in reading, and seems to need help." At the unit, individual tests administrated by the psychologist showed that the soldier was of border-line intelligence and could not meet the literacy standards of the army. A review of his social history by the social worker indicated that his civilian employment history had been made up of simple jobs, such as domestic work and washing clothes. He also complained of severe headaches, dizziness, and physical symptoms. After an interview and consideration of social and psychological reports, the psychiatrist referred him to the station hospital for physical check-up. The post surgeon's report stated that the soldier had a physical defect, making him incapable of performing manual labor and recommended him for reclassification into limited service. A Red Cross report revealed that both at school and in the community, he was considered "neither mentally strong nor well-balanced." The combination of border-line intelligence, limited-service status, and illiteracy rendered him incapable of performing useful military service. The unit, therefore, recommended to the commanding general that he be discharged under W.D. Circular 395. Such action was effected.

THE AMERICAN RED CROSS

In earlier sections of the report, frequent reference has been made to the use of the American Red Cross. This section will be concerned with a description of the place of the American Red Cross psychiatric social worker in the mental-hygiene unit.

In September, 1942, an American Red Cross psychiatric social worker was assigned to the mental-hygiene unit to administer the special services of the American Red Cross. In 1905, the American Red Cross was authorized by government charter to be the official social-service agency for, and the only means of direct contact between, the armed forces and the local community. Therefore, the Red Cross has a special contribution to make, not only to the service man, but also to the soldier's family at home.

In the mental-hygiene unit, the American Red Cross fulfills a threefold function. In the main, it acts as a liaison agency between the army and the soldier's local community. Thus, it is in a position to learn a great deal about the soldier prior to his induction. Such information, obtained and used on a confidential basis, is given to the workers of the mental-hygiene unit to supplement the information they have about the soldier with whom they are working. Writing to the local chapters of the American Red Cross for this information constitutes about 50 per cent of the work of the Red Cross in the unit.

The second function of the Red Cross in this unit is to give direct service on extra-military matters to the soldier who is being studied at the unit. The local chapters of the American Red Cross have been given the responsibility of providing care for the needy families of the service men. The Red Cross in this unit is often called upon to help the soldier through enlisting the aid of the local Red Cross chapter. It is often found that a soldier is unable to relate or to adjust himself to the army because he is too concerned and worried about what is taking place back home. Through coöperation with the local Red Cross chapter, it is often possible to ameliorate many of these problems, to reassure him that his family is being cared for, and, consequently, to free him to adjust to the army and to the job of being a soldier.

To the mental-hygiene unit has been delegated the function of recommending for discharge service men who, for various reasons, no longer can contribute to military service. Such men, discharged under various sections of Army Regulations, are referred to the Red Cross in this unit for assistance in rehabilitating themselves in civilian life. Prior to leaving the camp, each discharged man is given help in filing a veteran's

pension claim; in applying to the Selective Service board for reëmployment; in applying for assistance from a state vocational-rehabilitation service, if indicated; and in making plans for his return to civilian life. Since all army responsibility is ended once a soldier has been discharged from the service, the Red Cross plays an important part in bridging the gap between the army and civilian life. Each soldier is referred to his local Red Cross chapter upon his discharge; it then becomes their job to give the discharged man further assistance in his readjustment problems. This, then, is the function of the Red Cross in this unit.

The following case indicates the use made of the American Red Cross by the mental-hygiene unit.

Case 9.—Private D, aged twenty, of average intelligence, was referred because he was A.W.O.L. for the second time. The soldier had married just prior to induction. His wife was pregnant and had been living with his family. The family now had forced the soldier's wife out of their home. She had moved in with her married sister, but she was in poor health because of her pregnancy and was not able to get adequate care. Concern over his wife led the soldier to go A.W.O.L., the only way in which he believed he could assist her in getting medical care. Discussion with him of Red Cross facilities resulted in a reference of the case to the Red Cross worker in the unit, who was able to effect liaison between the soldier and his wife. Plans were made for regular contacts between the Red Cross worker and the soldier in which information could be exchanged and plans worked out to help him overcome some of his anxiety about the home situation. The wife was interviewed by a Red Cross worker in the city, guided in her problem, and provided with medical care. The soldier felt relieved and has been able to continue with full effort in his training and assignment.

SPECIAL PROBLEMS

Violation of Articles of War.—Violations of Articles of War impair the soldier's training program and thus interfere with the goals of the Signal Corps Replacement Training Center or of any military installation. Disciplinary action by a commanding officer or other officer, or by courts-martial trials, is provided for in such offenses under the provisions of Articles of War and Army Regulations. In referring offenders to the mental-hygiene unit, the command recognizes that the soldier has not been functioning responsibly, and is interested in knowing whether and how he can ultimately become useful to the army. Thus, there is a recognition that the violation is but a symptom of maladjustment which may

have far-reaching implications for the soldier's usefulness in the army.

In all cases in which courts-martial charges are filed, reference to the mental-hygiene unit is required. Also, an enlisted man who has been A.W.O.L. for more than twenty-four hours is reported to the unit immediately upon return to duty. He is assigned to the military psychiatric social worker, who gets his story. His army and civilian adjustments are then studied to learn what understanding they can contribute to the soldier's ultimate military adjustment. Where indicated, extensive investigation of his civilian life is instituted. When necessary, the skills of the psychologist are called upon. After this evidence has been gathered, it is presented to the psychiatrist, who sees the soldier for final evaluation and recommendation for disposition.

TABLE IV.—PERCENTAGE ANALYSIS OF COURTS-MARTIAL CASES REFERRED TO MENTAL-HYGIENE UNIT

	Per cent of cases referred			
	Period I	Period II	Period III	Total period
A.W.O.L.	15.1	46.7	23.4	85.2
Desertion	0.6	2.9	0.8	4.3
Intoxication	0.5	2.3	0.5	3.3
Insubordination	0.5	1.9	0.6	3.0
Venereal disease	0.1	0.8	0.5	1.4
Larceny	0.1	0.3	0.5	0.9
Miscellaneous	0.3	0.9	0.3	1.5
Total	17.2	55.8	26.6	100.0

In all cases, opinions are rendered on the basis of this total evaluation of the personality involved. In those cases in which the soldier shows no potentiality for meeting the standards required by army responsibility and living, for physical, intellectual, or emotional reasons, discharge is initiated. The majority of offenders are, however, potentially of value to the armed forces, and these are periodically seen at the mental-hygiene unit and helped to meet the responsibility that the army expects of them. The process by which this is achieved is discussed in the section on counseling.

In the year and a half covered in this report, the cases referred to the unit for violations of Articles of War totaled 17 per cent of the total case load. Table IV gives a per-

centage breakdown of the cases seen in the three six-month periods.

Of the violators as of July 1, 1943, approximately 60 per cent had been counseled and had satisfactorily completed their period of training. In 20 per cent of the cases, the unit primarily rendered an opinion to the courts-martial boards.

Of the total courts-martial cases, approximately 14 per cent, resulted in discharge action. Table V shows the types of discharge, and the percentage of cases under each.

TABLE V.—PERCENTAGE ANALYSIS OF COURTS-MARTIAL CASES DISCHARGED, BY TYPE OF DISCHARGE

Section II	*Per cent of cases*	
Psychoneurosis, severe	19.9	
Psychosis	10.4	
Physical disability	10.4	
Epilepsy	1.0	
Total		41.7
Section III		
Psychopathic personality		1.0
Section VII		
Desertion (psychopathic personality)		1.0
Section VIII		
Chronic alcoholism	20.8	
Psychopathic personality	18.8	
Homosexuality	2.1	
Enuresis	2.1	
Mental defective	1.0	
Total		44.8
Circular No. 395, 1942		2.1
Dishonorable discharge (psychopathic personality)		9.4
		100.0

The following case abstracts are illustrative of the Articles of War offender and the unit's method of working with him.

Case 10.—Private F. T., aged twenty, was referred by his company commander for being A.W.O.L. for ten days. He told the military psychiatric social worker of his ambition to become an air cadet. Just prior to induction, he had been attending an aviation cadet school with the hope of subsequently being able to enlist in the Air Corps. This hope was suddenly dashed when his local board classified him for immediate induction, and he did not have the opportunity to complete the civilian course. He was further disillusioned when placed in the Signal Corps and assigned to Message Center. When he was visiting his home town, several people joshed him about not getting into the Air Corps. This intensified his resentment and his inability to accept his Signal Corps

assignment. At this point, he went A.W.O.L. At the unit, it was pointed out to the soldier that he could apply for transfer to the Air Corps, although, from diagnostic tests given by the psychologist, it was indicated that his basic capacity was too limited for a cadet assignment. Nevertheless, he decided to institute application. A Red Cross report showed that he was high-strung and temperamental and had had difficulty in his school and home adjustment. The psychiatrist interviewed him and recommended leniency to the courts-martial board, accompanied by follow-up at the unit. The soldier was seen several times subsequently. At the completion of his course, he qualified as a Message Center clerk with a rating of "good." Although his application for transfer to the Air Corps was still going through channels, he was ready to accept his clerical assignment in a positive way and to continue in it should his application be disapproved.

Case 11.—Private A. L., thirty-two years of age, was referred by the adjutant after being A.W.O.L. three days. He gave a disconnected story of his offense, was tense and irritable and sullen, with ideas of persecution, threatening to do violence to himself and to others. Arrangement was made to have him transferred to the mental ward from the guard house and he was discharged to a state mental institution.

Case 12.—Private E. F., seventeen years old, was referred after being A.W.O.L. eight days. He told the military social worker that he had been assigned as a truck driver after failing the radio-operator course. Being of superior intelligence, with a strong drive for achievement, he felt frustrated at not being used in a more skilled assignment. He had decided to go A.W.O.L. in order to bring attention to his problem. During the interview with the military psychiatric social worker, it was discovered that he was red-green color blind, a disability that necessitated removal from Chauffeur School. On this basis, he was reclassified to Supply Clerk School. At the unit, he was helped to understand the limitations within himself that prevented his assignment to a more highly specialized job. He was able to accept his classification in a more responsible manner and was able to relate himself better to being a more capable soldier. He has been followed by the unit and is making an adequate adjustment.

Case 13.—Private G. M., a veteran of World War I, was referred after being A.W.O.L. for two days. He told the military social worker that he had been drinking and had fallen asleep while waiting for the train back to camp. However, he gave indication of being unstable, and a complete investigation was instituted. He was found to be inadequate and emotionally unstable, a person who had never gained satisfaction except through dependence on others and through drinking. He had a history of arrests for intoxication dating from 1916. He had been admitted to a Massachusetts institution for alcoholics eight times since 1937. He had been admitted to the two veterans mental institutions, where the diagnosis of "chronic alcoholism" had been made. His discharge from the service was effected through Section VIII proceedings.

The scientific classification and evaluation of prisoners, the formulation of programs for their rehabilitation and their return to military duty, and particularly the proba-

tionary aspects of the treatment of the military offender present a challenge to the use of the clinical team as herein described. Such factors as the emotional, physical, and intellectual status of the offender are necessary considerations where release from shorter or longer periods of confinement are being decided upon. In returning a prisoner to duty, a trial period under probation can provide for adequate follow-up work through a mental-hygiene facility. This is a principle long recognized in civilian agencies and modern penology.

Illiterate and Non-English-Speaking Soldiers.—An important part of the unit's case load were the men referred by the classification section as illiterate or non-English-speaking. These men were potential candidates for assignment to the special-training unit where, through special methods, their educational achievements and the use of the English language might be sufficiently developed to meet the minimum army requirements. These men are inducted into the army under current regulations. During the period under consideration the cases referred under these categories made up 9.2 per cent of the total case load.

Upon being referred to the unit, the soldiers are seen by the psychologist, who evaluates their educational achievement, their learning capacity, and their intellectual level of functioning. Specific tests used in this connection are the army information test, placement tests for special-training unit, 2abc non-verbal test, the army Wechsler intelligence scale, and standardized educational tests as required in particular cases.

The psychologist's report is given to the military psychiatric social worker, who then sees the soldier and discusses with him the meaning of his problem in relation to what his place in the army might be. The soldier's abilities and limitations are the focal point in this counseling process. In this initial sifting, one of several conclusions may be reached. The psychiatrist makes the final disposition on the basis of the combined significance of psychological, social, and psychiatric findings. The soldier may be referred to the special-training unit, assigned to a specialist course, or found useful as a basic soldier.

The prime consideration in this entire process is the service that the man can render to the army. Where the total study of the unit reveals that physical, intellectual, or emotional handicaps would prevent the soldier from rendering a useful service to the army, discharge proceedings are instituted under AR 615–360.

Of the total number of men considered for possible illiteracy, 49 per cent were referred to the special-training unit, and 15.5 per cent were assigned to school and qualified as specialists. Those not assigned to a special-training unit and unable to qualify for special-training skills, but capable of performing useful duties, were qualified as basic non-specialists, 14.5 per cent being placed in this category. Twenty per cent were discharged from the army and .5 per cent were found sufficiently qualified in a skill for assignment to special jobs.

Case 14.—Private S. C., a twenty-year-old American-born soldier of Italian parents, was referred to the mental-hygiene unit as inapt. Psychological examination indicated that, although he had high average intelligence, he barely met the minimum army literacy standards because of a reading retardation. Seen by the military social worker, this soldier was found to have been reared in an Italian community in the eastern United States. He had been compelled to leave school after the fourth grade because of illness and because he had to work to support his parents. He had made an adequate social adjustment and had an excellent employment history as a truck driver. His particular difficulties arose out of his inability to read notices on the bulletin board and his shame about admitting this fact. Having been a truck driver, he requested a similar assignment in the army. However, he could not read well enough to handle trip tickets and other clerical details necessary for a military truck driver. He was assigned to the special-training unit for literacy training and eventually qualified as a truck driver.

Emotional Problems.—The soldier who comes to a replacement training center has previously experienced emotions about his entrance into army life. He may have looked forward to it or feared the new demands it might put on him, or he may have experienced both feelings simultaneously in varying degrees. It is only as he faces each new step in his transition from civilian life that he can begin to know and react to the everyday experience of army living. By the time he reaches the E. S. C. R. T. C., he has already completed the two prior steps, processing by the induction and reception centers. His enthusiasm or disappointment, his joy or shock

on being inducted will have influenced his attitude toward the army.

At the E. S. C. R. T. C., the soldier is assigned to a program geared to training individuals for combat work. How the so-called "green" soldier adjusts to his specific training assignment will depend not only on his aptitude, physical make-up, and intellect, but also upon his emotional attitudes and feelings. He will have to learn not only to perform a particular duty, but also to live and work with groups, to sleep and eat under different conditions from those he experienced in civilian life, and to comply with more stringent requirements of discipline than he has heretofore been required to face. Each soldier's reaction to the complexity of factors thus involved will depend on his strength and limitations as a personality, reacting under new conditions of stress and strangeness. Most soldiers are sufficiently equipped as individuals to adapt themselves to army life without any special assistance.

On the other side, however, is the type of soldier who shows, in obvious or subtle ways, that he is "out of step" with the army. His dilemma may show itself in specific, objective ways or in a general, less defined manner. He may be fearful of climbing a pole, may break down on the firing range, or may act in an insubordinate, defiant way. There may be bed-wetting, insomnia, vague physical complaints, a general state of anxiety or nervousness, loss of appetite, inability to drill or to sleep, or a chronic feeling of jitteriness. When men are additionally handicapped by a physical or intellectual deficiency (illiterates, non-English-speaking soldiers, slow learners), their anxiety tends to be further aggravated.

The soldier who suffers from severe, chronic emotional tension or who shows definite, overt, nonconforming tendencies—homosexuality, enuresis, and so on—may have performed satisfactorily on his job in civilian life, since the constant demands of those living situations were less exacting than those required by army standards. The strict requirements of self-activity and initiative, under orders in the army, will tend to remove these familiar supports of family and routine that have helped the man carry on his duties.

In addition, there are those men who fall into the severe

psychoneurotic and psychotic group and who cannot function at minimum adequacy, either in civilian or military life. These categories include men who are so fundamentally disturbed as to be considered "mentally ill." Discharge proceedings are initiated as soon as they are noted.

On the other hand, some soldiers, who are in a confused emotional state and therefore not able to apply themselves fully to their army duties and assignment, may be able to act more efficiently after personal guidance.

The number of cases seen by the unit whose problems were heavily weighted on the emotional side constituted 18.8 per cent of the total number of men seen. They may have been referred for behavior that called attention to the soldier by making him appear generally different from the group. It may have taken him an hour and a half to shave, he may have written five letters home to his mother in one day, or manifested some equally bizarre behavior. The more obvious cases, such as enuretics, homosexuals, and alcoholics, are also included in this group.

Of the men who presented emotional problems or demonstrated peculiar behavior, the unit followed up 81 per cent who showed potentialities for army service. By counseling, reassignment, and use of other army resources and through psychotherapeutic methods, these men were helped to initiate the taking on of constructive responsibility as soldiers. Some soldiers were seen over a short period and some over a longer period, depending on the nature of their problems and how long they would remain at the E. S. C. R. T. C. The remaining 19 per cent were found to have deep disturbances and to be unable to perform any positive service, and so were discharged via C.D.D., Section II, Section VIII, and Section X, AR 615–360.

The following cases are illustrative of such problems:

Case 16.—Private J. A., a twenty-two-year-old soldier of average intelligence, was referred to the mental-hygiene unit by Wire Line School after he had refused to climb a pole, an essential requirement for qualification. This soldier was an Army Air Corps man attached to the E. S. C. R. T. C. for special signal training and, unless qualified, he would have to be shipped back to the Air Corps base for reclassification. Seen at the unit, this soldier expressed fear and indecision. Originally, he had climbed the pole successfully and had almost fallen, an incident that grew in his mind as he began to have difficulty in adjusting to the army. Review of his civilian adjustment by the military psy-

chiatric social worker indicated that he was a somewhat timid, immature man, who had been dependent on his parents for help in making decisions and in facing unpleasant situations. In the army, he found himself unable to depend on anybody but himself, and his inability to make an adequate mature adjustment caused great anxiety, which was ultimately expressed in a fear of pole climbing. Through the counseling process, his army adjustment was discussed with him and the soldier was able to recognize some of the basis for this fear. As he was also fundamentally a person who wanted to be successful, he also recognized that unless he met his fear of climbing the pole, he would leave the camp untrained. Still undecided, he left the unit to think things through. The following day he returned to ask another opportunity to try climbing a pole. Subsequently, he successfully met the requirements of the school.

Case 17.—Private K. W., a twenty-year-old soldier of low average intelligence, was referred to the unit because he was very nervous and tense and had overstayed his pass several hours because of his confusion about trains. Called into the unit, he appeared extremely morose, claimed that he couldn't sleep or show any real interest in anything and had little appetitie. As the situation was further discussed with him, the soldier saw as its core his growing concern over the condition of his wife and his two children. His enlistment seemed to have grown out of his immaturity, his impulsiveness, and his unexpressed desire to evade the responsibility of so large a family. Unable to get into the Air Corps, as he desired, he had begun to feel lonely and, as a result, was unable to function adequately within the company. Psychiatrist and social worker discussed the general problem with him and what he himself could do to modify the situation. Since discharge was impossible, he began to face more realistically the possibility of getting ahead in the army and earning enough to support his wife and children. To the degree that he became involved in the discussion of possible things that might be done, his anxiety seemed to diminish.

After consultation with the unit, the company commander granted him a pass to return home, visit his family, and institute some additional measures for their care. After his return, he was seen again at the unit and the question of classification was discussed more fully with him. It was found that he had enlisted originally for the Air Corps, and that he possessed a skill that was particularly useful in that branch of the service; a recommendation was therefore made for his reassignment to the Air Corps. Meanwhile, he was reclassified to the Auto Mechanic School. In a follow-up interview, the soldier felt that things were going well with him and was prepared to go on in the Signal Corps, even though the transfer was not effected. The school reported him as making satisfactory progress.

Case 18.—Private J. F., aged thirty-one, of superior intelligence, was accepted for induction with a classification of "limited service" because of "loss of distral phalynx, right hand, and psychoneurosis, mild." He was referred to the unit for evaluation of the suitability of his training assignment, in view of his limited-service status. Seen at the unit by the military psychiatric social worker, he was observed to be rather effeminate in physical mannerisms. In civilian life, he had been teacher, artist, draftsman, and musician. Yet, in the army, despite his rich background, he was doing marginally passing work in his school assignment. He

mentioned that he could not bring himself to be interested in the work. There was something he "had held within himself" since induction into the army. He felt that if things continued as they were, he would have a nervous breakdown.

Since the age of twenty-one, he had indulged in homosexual activities. Prior to induction, his anticipation of living with groups of men frightened him so that he sought a psychiatrist. Advised by the latter to seek deferment on the basis of his homosexuality, he found at that time that he could not face the "public shame" of making this known to the induction board. Psycho-diagnostic tests given by the psychologist indicated disturbances in the area of sexual adjustment. The Red Cross report verified the soldier's statements. It also confirmed the statement that he had been employed as a draftsman and that his firm had been unable to replace him. On the basis of psychiatric examination and a review of all social and psychological data, the psychiatrist made a diagnosis of "homosexuality" and recommended discharge via Section VIII, AR 615-360, which was effected.

Psychosomatic and Somatic Limitations.—During the last seven months covered in this paper, there was an increased induction of men whose physical condition was such that, while they could not perform under full field conditions, they were able to render valuable service to the army despite their limitations. These soldiers were given a "limited service"[1] status.

It has been established by E. S. C. R. T. C. directive that all requests for physical or mental examinations of personnel assigned or attached to the center be routed through the mental-hygiene unit. Therefore, in these cases it is the responsibility of the unit to evaluate carefully the individual who presents symptoms or disabilities either on arrival or subsequently.

The director of the unit is a medical officer attached to and functioning directly with a line organization. He is also the president of a board of medical officers within the E. S. C. R. T. C. This makes available to the command a resource that facilitates the diagnosis of medical limitations and relates them to the performance necessary for a soldier in every assignment in the Signal Corps. Further, the command has an officer responsible to it, which makes possible professional liaison with the post surgeon. This dual understanding and single administrative responsibility make for a most effective coördination of army needs with mental-hygiene principles.

[1] This category has been discontinued pursuant to a recent War Department directive.

Since a mental or physical handicap affects each soldier differently, depending upon other factors in his make-up, it becomes necessary to evaluate carefully each man's personality assets, so that he may be of the greatest possible usefulness to the army, despite his partial disability. This demands a skillful analysis by the psychiatrist of his emotional strengths and weaknesses, and an appraisal of his capacities and potentialities by the psychologist. When these steps have been completed, the military psychiatric social worker coördinates the information obtained with his knowledge of the nature and requirements of training assignments. This is done in discussion with the soldier, so that he is permitted to participate in the final decision, which is the responsibility of the director. Such emotional factors as are bound to come to the surface as a result of the change in status are handled in this counseling process.

In all cases referred to the unit, whether the soldier is referred specifically for an evaluation of his physical or mental condition or, in cases referred for other causes—such as school failure, violation of Articles of War, and so on—when a discussion of the soldier's difficulties gives rise to a question as to his physical fitness for full field duty, he may be referred to the post surgeon for physical examination. This often serves the purpose of ruling out organic involvement in cases of psychosomatic syndromes and is an invaluable aid in differential diagnosis. In some cases, conditions previously unnoticed will be determined and appraised; in others, where old injuries have become aggravated by the increased pressure of the training program, a channel is ready at hand for the referring of the man to the hospital and for an evaluation of his changing status, which is often accompanied by a change in assignment. In this way, the individual receives the consideration intended by army directive, to the end that the army may receive the maximum service that each soldier is capable of rendering.

Since the unit has had the responsibility for processing this type of problem, 49 per cent of its total case load has been referred to the hospital for physical examination. In view of the changing nature of physical and mental health and the changes in the status of the soldiers during their period of training, some who showed evidences of symptoms

or disabilities at induction stations may have gained weight or undergone corrective operations, so that their status warrants change to general service. Conversely, men who were thought to be of general service may have developed disabilities sufficiently severe to warrant change to limited service. In both of these groups, there were men whose disabilities warranted discharge because of their extreme limitation or lack of usefulness to the army. A percentage analysis of the dispositions made of all cases referred to the station hospital shows the following distribution:

		Per cent of cases	
I.	Soldiers arriving in limited service and rechecked:		
	a. Retained in limited service	23.4	
	b. Reclassified to general service	2.0	
	c. Discharged via Sections II and X	0.6	
	Total		26.0
II.	Soldiers arriving in general service and reclassified to limited service:		
	a. Shipped as limited service	26.8	
	b. Reclassified to general service	0.8	
	c. Discharged via Section X	3.5	
	Total		31.1
III.	General service soldiers referred for physical examination whose symptoms or disability was insufficient for limited service		25.1
IV.	Pending disposition		17.6
			100.0
V.	Disabilities for which soldiers were placed in limited service:		
	a. Eyes	46.3	
	b. Feet	14.4	
	c. Old injury	9.9	
	d. Neuropsychiatric disorder *	8.0	
	e. Lack of stamina and underweight	5.5	
	f. Ears	4.7	
	g. Arthritis	1.8	
	h. Back	3.3	
	i. Miscellaneous	6.1	
		100.0	

* This category no longer exists, since men with any psychiatric limitations must now be discharged by directive.

Responsibility for these cases is a continuing one which has an important bearing on the soldier's adjustment, as

his condition either responds to treatment or increases in severity as a result of exposure to the training program. The unit, through liaison with the infirmary, has the responsibility for deciding whether or not the soldier can perform in a manner commensurate with his condition.

That the unit recognizes and meets its responsibility for a continuing reëvaluation of the soldier's adjustment in the army is indicated by the fact that in 14.8 per cent of the cases, the unit initiated a re-reference of the case for further examination. A number of this group, 3.8 per cent, at first found to be of limited service, were discharged via Section II, AR 615–360, after trial of duty or further consideration by the unit indicated that these soldiers would be unable to render service as defined in Army Regulations.

The distribution of disabilities of the men who completed their period of training with limited-service status is indicated in Item V of the foregoing tabulation. In each case, an evaluation of the soldier's limitation, of his assignment, of his native intelligence and ability to learn a new skill, of his vocational experience, and of other personality factors had to be made. This was necessary, since limited-service soldiers who had not the intelligence necessary to learn an army skill rapidly, who had no civilian skill that could be used by the army, and who were not able to do manual labor day after day, were dischargeable under WD Circular 395, December 5, 1942.

Through its several members of the clinical team, the unit is able to evaluate the soldier's total personality and to meet the command's need for training and assignment of this group of soldiers. In 14 per cent of the cases placed in limited service, it was found that, in his current assignment, the soldier's limitation constituted a danger to himself and a hazard to the service. Reassignment in these cases was so coördinated that the soldier's value to the army was realized by his ability to meet fully the requirements of a job in which his limitation was not a disqualifying factor, and he was able to qualify as an army specialist. The percentage of soldiers who, after evaluation, were thought to be able to continue in their assignment and who were able to qualify without reclassification, was 58 per cent. During the time interval covered

by this paper, 28 per cent were still attending schools and were expected to qualify.

Indicative of the rôle of the unit in handling this type of problem for the command is the manner in which the E. S. C. R. T. C. was able to fulfill the change in regulations that called for the discharge of all soldiers who had been placed in limited service because of psychiatric limitations. This category comprised 8 per cent of the soldiers who were at that time in limited service. The unit was quickly able to determine who these soldiers were and whether they were still in camp, and immediately referred them to the post surgeon for discharge.

The data in the tabulation indicate that of the total number of soldiers referred for physical examination, 87.7 per cent were able to complete their period of training or were still attending school. In 12.3 per cent of the cases, a discharge from the army was effected. Of primary significance in dealing with this group of cases is a knowledge of the specific nature of the soldier's limitation and a clear understanding of the requirements of the several E. S. C. R. T. C. schools.

It is only with the administrative set-up of the unit, which operates in direct relationship to the school, the company commander, the classification section, and so on, that the army can make the most adequate utilization of the services of the soldier who, although he presents some limitation of function, is not dischargeable under present army regulations and can render valuable service to his country if properly evaluated and assigned. What may be the deciding factor in many instances will be the constructive handling of the soldier's feelings and attitudes toward his problem.

As in civilian life, the question of an individual's mental and physical health is one that undergoes continuous change. There are periods of prolonged good health and productivity, of temporary upset or disability, of chronic complaint, and the multitudinous variations within these conditions. Ideally, in all cases the resources of a mental-hygiene unit, as herein described, should be brought to bear. It is through this approach that the most adequate evaluation of personality can be made. The problem involves determining not only the probable duration and degree of the limitation, but also the manner in which the soldier's potentialities can best be used

by the army. It is in carrying the continued responsibility for this group that the awareness of mental-hygiene factors in personality and the skillful use of the techniques in the counseling process are most necessary.

Case 19.—Private R. M., a thirty-two-year-old soldier of superior intelligence, was referred to the mental-hygiene unit by the infirmary. He was examined at the hospital, found to have a recurrent dislocation of cartilage of the left knee joint, and was placed in limited service. Investigation showed him to be doing very well where pole climbing was necessary. He was called in for an interview. After discussion, it was recognized that, while he was able and satisfied with his assignment, his limitation, under field conditions, would present an additional hazard to himself, as well as to the men depending upon his ability. Further discussion revealed some background in clerical work, and he was accepted for Supply Clerk School. Reclassification was effected with the request that additional training time be allowed to permit him to qualify. A subsequent interview showed that the soldier was doing well in his new assignment and was to qualify as a supply clerk. Follow-up shows that this soldier qualified in his training school and was assigned to a permanent position at this post.

CONCLUSION

This paper has presented the mental-hygiene unit in action within the Signal Corps Replacement Training Center. The keynote of its work has been the coördination of the various skills—psychiatric, military psychiatric social work, and psychological—toward meeting the problems experienced by individual soldiers in their efforts to achieve military usefulness, under the changing conditions and requirements of the E. S. C. R. T. C.

There are several fundamental implications that underlie the content of this report as described. The mental-hygiene unit should be considered as only one of the sections within this command whose ultimate purpose is to achieve the best possible utilization of man power assigned here for training. The staff required to deal with these problems was selected on the basis of its professional training and experience.

The successful working of this unit is made possible because it derives its function from and is solely responsible to the commanding general. The areas of the unit's responsibilities have been defined in official directives as indicated. Herein is set forth the scope of its work. The director of the unit, as a member of the commanding general's staff, is thus in a position to bring to bear all the resources of the army in meet-

ing each problem. Some of these functions are new to the work of a replacement training center. Many of them represent ways of meeting problems for which there were no other facilities. None of these methods are in contradiction to or duplicate already established procedures. The directives provide for liaison with the total replacement training center's program.

As has been noted throughout this paper, the primary use of the clinical team has been to focus its service to this command toward the alleviation of problems of military maladjustment among its trainees. Many of these problems have been qualitatively related to the E. S. C. R. T. C., such as reclassification from one Signal Corps school to another. Specific Signal Corps requirements had to be considered here. Many other problems of soldiers in this command existed, created by their own difficulties and by the general elements of military service itself.

Thus, it can be stated that the nature and variety of problems presented by soldiers fall into two large groups: those that arise from the specific nature of their army responsibilities and those precipitated by their own personality problems in relation to military service. An extension of this basic premise can be applied to any military installation where both quality and quantity of military duties are always present and where, in addition, the factor of general psychological stress is in constant operation. These vary in kind and degree from one branch of service to another, as well as from the lowest to the highest echelon of training and field operations. New situations and responsibilities will always give rise to new problems. Where a soldier may be capable of sustaining a good military adjustment during the early stages of his training, new factors of stress are very likely to give rise to problems in later phases of army life.

With its generic approach and inherent flexibility, the clinical team can meet the challenge of problems as they require handling in any military installation. The clinical team is designed to function efficiently and fully in the treatment or disposition of problems of military adjustment, as has been demonstrated in this type of installation since it was established on January 1, 1942.

In the completeness of skills available and the resulting coverage of personnel problems, the clinical team, as represented in the mental-hygiene unit, is a service to the armed forces. In looking to post-war planning, however, we should not lose sight of the challenge that will come with the tremendous task of demobilization. Such problems as the scientific reallocation of man power to industry, vocational guidance of a highly specialized nature, and the whole field of the various forms of care and rehabilitation of the neuropsychiatric casualty will require the best of skills. The inherent flexibility of a clinical team, as described here, can be made of service to this country in peace as it now serves in war.

CLIFFORD WHITTINGHAM BEERS

IN THE passing of Clifford Whittingham Beers, on July 9, 1943, America—and indeed the world—lost a great humanitarian—one whose name will always be identified with the founding and launching of the mental-hygiene movement. The dramatic story of Clifford Beers's life and his unique achievements have been vividly portrayed in his widely read classic autobiography, *A Mind That Found Itself,* and his subsequent publication, *Twenty-five Years After.* In these two volumes is presented the amazing record of this remarkable man, who dedicated his life with complete singleness of purpose to the improvement of facilities and methods for the prevention and treatment of mental disabilities.

The zeal that motivated him for his task resulted from his personal experience as a mental-hospital patient. This experience left him with the conviction that existing methods of dealing with mental illness were grossly inadequate and, despite the fact that his college training was confined to engineering, with no exposure to medicine, he ventured forth on his life mission. The innumerable obstacles and difficulties that confronted him were surmounted. He succeeded in securing the active collaboration of some of the ablest psychiatric leaders. He captured public imagination; raised considerable sums of money for his constructive programs; organized mental-hygiene committees throughout the world; and profoundly affected the development of psychiatry. Indeed, the impetus he gave to the progress of psychiatry was his most notable achievement and deserves special recognition at this time, when the American Psychiatric Association is about to celebrate its hundreth anniversary and is now reviewing the signal advances in its field during the last century.

When Clifford Beers began his work, American psychiatry had not achieved the status that it enjoys to-day. It was hampered by many handicaps. Public mental institutions, which employed the great majority of men engaged in the

psychiatric field, were inadequately financed and, for the most part, were organized for custodial care, with scant arrangements for active therapy. Under these depressing conditions, psychiatrists were thwarted in the conduct of necessary research, in the development of high professional standards, and were becoming more and more isolated from their colleagues in other branches of medicine. The general public was apathetic to this unfortunate situation and there was little incentive to psychiatry to transform asylums into creditable hospitals, to convass possibilities for prevention, or to embark upon programs to improve the mental health of all sections of the population.

Clifford Beers quickly realized that psychiatry could not be expected to extricate itself from its difficulties through any tugging at its own boot straps. He sensed the fact that what was needed was a great awakening of the public conscience which would create an irresistible demand for a loosening of purse strings on the part of governmental bodies and would insist upon progress. With this conviction, Mr. Beers, with unshakable determination, set himself to the task of directing public attention to this neglected field and to the setting up of arrangements for a working partnership between the public and psychiatry. He publicized his fascinating life story to capture wide interest. With the collaboration of Dr. Adolf Meyer, he introduced the intriguing title "Mental Hygiene" to designate his pioneering program and, with the backing of influential friends, he organized mental-hygiene societies.

His most potent instrument proved to be The National Committee for Mental Hygiene because of the fortunate circumstance that there was secured as its first medical director Dr. Thomas W. Salmon—a truly great man with a genius for inspiring, courageous leadership. The constructive activities of the National Committee led to the raising of mental-hospital standards; to a setting of the stage for extramural psychiatry; to the stimulation of public and professional education in mental hygiene; and to the opening of doors for the integration of mental-hygiene thought, philosophy, and practice into such disciplines and fields as medicine, social work, education, religion, and industry.

It is not too much to say that Clifford Beers's work was of an epochal character—that it played a major rôle in elevating

psychiatry to a higher and more productive plane of service. And while it is true that other forces were operative, that psychiatry was becoming more dynamic and interpretative because of the contributions of able men, nevertheless the fact remains that Beers, the layman, made possible a job of medical and social engineering that was of strategic importance and that cannot be left out of account in viewing psychiatric progress during the last thirty-five years.

It is hoped that the lessons of Clifford Beers's life will not soon be forgotten. Unfortunately, there is a danger in this direction because of the very circumstance that psychiatry has, at last, become strong and powerful. With wide memberships in professional psychiatric associations and with improved status in universities and medical circles, there may be a disposition on the part of psychiatrists to feel that they can get along well enough without the assistance of mental-hygiene committees—without the help of organizations that dedicate themselves to the task of developing an intimate partnership between psychiatry and the general public in fostering progress in this field. In other words, there may be a disposition to forget or to ignore the thing that Clifford Beers stood for—the indispensable need for establishing and maintaining ever closer team play with the lay public. And if psychiatry forgets Beers and his lesson by failing to insure the adequate financing and support of such organizations as The National Committee for Mental Hygiene, then psychiatry and the public it serves will be the losers. No great health movement can possibly achieve its end without the understanding, interest, and good will of the public.

It would be a fitting tribute to Clifford Beers to endow his most promising and productive venture—The National Committee for Mental Hygiene. And, in connection with a national campaign for such a purpose, American and Canadian psychiatry would, I believe, consider it a privilege to play an active part.

C. M. Hincks

LEWELLYS FRANKLIN BARKER

THE summer of 1943 must record the death of one of our greatest leaders in medicine. Lewellys Franklin Barker rounded out seventy-five years of valuable and illustrious living as a physician and as a man. His brilliant career reached its full stature in 1905 when, at the age of thirty-eight, he was chosen as successor to Osler for the chair of medicine at the Johns Hopkins Medical School and Physician-in-Chief to the Johns Hopkins Hospital. Certainly ambition and accomplishment met early in this brilliant personality.

A backward look at his accomplishment makes understandable his rapid rise to fame. In 1899, at the age of thirty-two, he had published what was to be a classical work on neurological histology, *The Nervous System and Its Constituent Neuroses.* This large volume was written in one year and has stood the test of time so thoroughly that Adolf Meyer once said that after thirty years there was hardly a statement that needed change or correction.

Barker came to clinical medicine through the sound and thorough route of anatomy and pathology. He taught anatomy at the Johns Hopkins Medical School from 1894 to 1897, and then joined the department of pathology while he still was teaching anatomy. He continued in pathology until 1900, when he was called from the Johns Hopkins group to become professor of anatomy at the University of Chicago.

During his five-year stay at Chicago, he began to realize his first and foremost ambition—his entrance into clinical medicine.

In 1905 he entered upon his duties as Physician-in-Chief of the Johns Hopkins Hospital and served brilliantly as its medical head until 1913, when he retired to become clinical professor of medicine. Although he was a strong advocate of giving full-time clinical medicine a real trial, he was forced by personal obligations to refuse, reluctantly, to be the first full-time professor of medicine.

Dr. Barker's contribution to the medical clinic at the Johns Hopkins Hospital was a reflection of his most outstanding talent—an ability to organize from the point of view of a

mind that could gather together all the soundest nowledge of his own time and of the past. His was not a talent for original investigation. "My deepest regret," he said, in his autobiography, "was that, owing to shortcomings in my nature, I was not to become an original investigator of importance myself."

In his all-too-short nine years as Physician-in-Chief to the Johns Hopkins Hospital, he organized and established laboratories in physiological, biological, and biochemical research. In the physiological laboratory, he started one of the first electrocardiographic centers.

Great as was Barker's admiration for the accomplishment during the Osler régime, he felt the urgent need to supplement the medical organization at Johns Hopkins by clinical and therapeutic study of the functional nervous disorders. His studies and observations in France, coupled with his interest in neurology, had convinced him that the Johns Hopkins Clinic must include better understanding and treatment of the psychoneuroses. Even in his first year as physician-in-chief he treated eighty patients psychotherapeutically and began to report and publish his work in psychotherapy.

Dr. Barker's interest in psychiatry never flagged, nor did he ever neglect the use of psychological understanding of his patients.

After his appointment as professor of clinical medicine, he developed one of the most successful private practices in the United States. He was insistent in his belief in the thorough and complete examinations of all patients, by all available clinical and laboratory methods, and this always included a psychiatric study and a personality evaluation. Barker was never bothered by the problem of soma and psyche. He treated disorder when and where he found it, and made use of whatever sound methods came to hand. It has been said that he was the first psycho-somaticist.

Dr. Barker's keen interest in psychiatry made him the logical person to help in the choice of a psychiatrist-in-chief for the Henry Phipps Psychiatric Clinic when that addition at Johns Hopkins Hospital was realized. Dr. Barker had for years projected in his mind's eye a psychiatric department before Mr. Henry Phipps's gift made possible its development at Johns Hopkins. Dr. Barker was on the committee that selected Adolf Meyer.

In 1909 Dr. Barker became the president of The National Committee for Mental Hygiene and served wisely in this capacity for nine years. He was also extremely interested and active in its activities both before and after his election to the presidency.

Dr. Barker's capacity to do an incredible amount of work, his great ability to organize his time, plus his prodigious memory, enabled him to become a medical encyclopedist of the first order. His three volumes, published in 1916, under the title, *The Clinical Diagnosis of Internal Disease,* are a model of completeness and sound brevity. He repeated the same task for endocrinology by editing and organizing, with the help of Mosenthal and Hoskins, a five-volume work (1922), which covered this field as thoroughly as the time permitted.

The list of Dr. Barker's publications in all the fields of internal medicine, neurology, psychotherapy, and endocrinology would fill many pages. He was constantly preparing surveys of the latest information as it was delivered from laboratories and clinics.

He was a great physician and contributed much to medical science, but he was also a great contributor to the lives of the people around him. He was generous beyond belief. He always encouraged young men of promise about him and was unostentatiously prepared to help them financially to promote their careers. I remember the story of one of his associates who hesitatingly announced that he was going into practice for himself. Instead of resenting a rival, Dr. Barker gave the young physician a large check with which to start his competing practice.

Dr. Barker was generous in opinion, was ideal as consulting physician, and had a way of always praising any medical help he asked for. I served as a psychiatric consultant to his large and interesting practice for twenty years, and those twenty years of association were never marred by a single unpleasantness.

I know of no one who came into his sphere of influence who did not love and admire him, and feel under an obligation to his greatness.

American medicine has lost one of its great leaders.

LESLIE B. HOHMAN

CHARLES MACFIE CAMPBELL

MENTAL hygiene and psychiatry have lost one of their most illustrious and brilliant members in the death of Dr. C. Macfie Campbell, professor of psychiatry at Harvard Medical School and Director of the Boston Psychopathic Hospital.

Dr. Campbell was born in Scotland in 1876. His college and medical education was received at Edinburgh, where he received his A.M. in 1896, his B.Sc. in 1900, his Ch.B. in 1902, and his M.D. in 1911. Following his Ch.B. at Edinburgh in 1902, during 1902 and 1903, he studied at the Hospice de Bicêtre, where he worked under Pierre Marie, and at Heidelberg Irrenklinick where he studied with both Nissl and Kraepelin. The next year he was an intern at the Royal Edinburgh Infirmary.

In 1904 he came to the United States and started working under Adolf Meyer at the Psychiatric Institute at Ward's Island. He worked there at the Pathological Institute from 1904 to 1907. He then returned to Scotland and was Assistant Physician at the Royal Edinburgh Asylum during 1907 and 1908, but again returned to the United States in 1908 as Associate in Psychiatry at the Psychiatric Institute, Ward's Island, where he remained until 1911. In 1911 he went to Bloomingdale Hospital, White Plains, New York, as First Assistant Physician, remaining there until 1913, at which time he rejoined Dr. Meyer, at the Johns Hopkins Medical School as Associate Professor of Psychiatry.

In 1920 he left the Johns Hopkins Medical School and the Phipps Institute to become Medical Director of the Boston Psychopathic Hospital and professor of psychiatry at Harvard Medical School, which positions he held up to the time of his death.

His teaching work was at three medical schools. He was instructor in psychiatry at Cornell University Medical School from 1909 to 1913. He was associate professor of psychiatry at Johns Hopkins Medical School from 1913 to 1920. He was professor of psychiatry at Harvard Medical School from 1920.

During World War I he helped in the training of neuropsychiatrists at the Johns Hopkins Hospital. He entered the U. S. Army on November 8, 1918, just before the Armistice.

To list his publications, society memberships, and activities would require so much space that mention will be made here of only a few of them and those particularly relating to mental hygiene. Dr. Campbell was one of the early members of The National Committee for Mental Hygiene. He was a member of the editorial board of MENTAL HYGIENE from 1917 to 1931 and was a frequent contributor, especially to the earlier issues. The first issue of MENTAL HYGIENE, that of January, 1917, contains an article by him, *The Subnormal Child: A Study of the Children in a Baltimore School District.* This was an account of a survey of the school population in the Locust Point District of Baltimore, which Dr. Campbell organized. It is interesting to note that the results of that survey and of the recommendations that sprang from it were discussed in the April, 1933, issue of MENTAL HYGIENE in a paper by Dr. Ruth Fairbank entitled *The Subnormal Child—Seventeen Years After.*

His broad interests in the field of mental hygiene are indicated by the following papers, which appeared in succeeding issues in the magazine: in April, 1917, *Educational Methods and the Fundamental Causes of Dependency;* in October, 1917, *The Mental Health of the Community and the Work of the Psychiatric Dispensary;* in April, 1918, *A City School District and Its Subnormal Children, with a Discussion of Some Social Problems Involved and Suggestions for Constructive Work,* a further account of the Locust Point survey; in January, 1919, *Nervous Children and Their Traning;* in April, 1919, *The Responsibilities of the Universities in Promoting Mental Hygiene;* in April, 1920, *Experiences of the Child, How They Affect Character and Behavior;* in July, 1920, *Minimum of Medical Insight Required by Social Workers with Delinquents.*

In addition to serving on the staff of the journal, Dr. Campbell was Chairman of the National Committee's Advisory Committee on Education from 1919 through 1937. He was also an honorary vice-president of the International Committee on Mental Hygiene.

Dr. Campbell was also most influential in the American Psychiatric Association, having been president of that organization from 1936 to 1937. He was President of the American Psychopathological Association in 1918, and Vice-president of the American Neurological Association in 1939.

Under Dr. Campbell's influence, the Boston Psychopathic Hospital became one of the most important training centers in this country for young psychiatrists, and many physicians from foreign countries came to study there under his guidance. His attitude toward psychiatry was one of eclecticism. He objected to the slavish acceptance of any particular theory. He saw much of value in most of the formulations of the different schools of psychiatry and felt that one should comb over all such material carefully, accepting what was of value and rejecting what was not.

His attitude toward psychoanalysis has often been described as ambivalent. He had a most complete and thorough knowledge of Freud's writing. He studied under Jung one summer and was thoroughly familiar with Adler's formulations. He would frequently call attention to some very special point which Freud had made as applying to the problem at hand. He had no hesitation in accepting many of Freud's formulations, but was equally free in rejecting others. He insisted that it was not a question of completely accepting or completely rejecting Freud, but rather a matter of finding out what was worth while in Freud's formulations and then utilizing such material. He would often say, "It is only a waste of time quarreling with the psychoanalysts about certain formulations. We should encourage them to continue their work and demonstrate what they can do. After all, time will tell which of these formulations are worth while and these will endure. Meanwhile it is better for us to get on with the particular work in which we are interested than to spend our time in unprofitable arguments over psychoanalytic formulations."

While recognizing Meyer's great contributions and accepting his concept of the total personality, he never made use of the special terminology of psychobiology as developed by Meyer.

Dr. Campbell's fundamental ideas are best given in two small books, *A Present-day Conception of Mental Disorders*

and *Delusion and Belief*. These books exemplify his idea that truth can best be formulated in simple, ordinary English. A master of the English language himself, he was most critical of works which did not carry such simple and clean-cut formulations as he himself was accustomed to produce. This was particularly true with regard to those working under him. He would constantly interrupt at conferences to insist that things be formulated more clearly and more simply. The result was that those who trained under him were forced to formulate all of their ideas in such fashion.

Dr. Campbell will be mourned by his many pupils and friends. His death is a great loss to psychiatry.

KARL M. BOWMAN

BOOK REVIEWS

WAR AND CHILDREN. By Anna Freud and Dorothy T. Burlingham. New York: Medical War Books, 1943. 191 p.

This book is an outgrowth of the authors' work with children whose families have been shattered by the war and who need specialized care and attachment. It is by no means a final report. The authors are very careful about making generalizations or offering explanations. War-time events are used here for an "experimental" study of the young child's relationship to his parents and parent substitutes. The inferences will be as valid in peace time as they are now under the strain of war.

The lucid chapter on the various types of air-raid anxiety will be valuable to any one confronted with the task of helping children who are upset by fears and anxieties. The five types described are: (1) the child who comprehends the real danger, (2) the child who interprets air raids as punishment for naughtiness and disobedience, (3) the child who shares his mother's anxiety, (4) the child to whom an air raid brings back the shock of bereavement, and (5) the slightly older child who abhors violence in order not to be seduced to commit it himself. The presence of children at acts of violence, aggression, destruction is not restricted to war time. An increased understanding of children's anxiety is an evident gain for peace time.

The authors want the reader to be well aware how the war's consequences for family life outweigh for the young child the grave immediate danger. "The war acquires comparatively little significance for children as long as it only threatens their lives. . . . It becomes enormously significant the moment it breaks up family life and uproots the first emotional attachment of the child within the family group."

In order to appraise rightly the success and failures of placements, the children's phantasies and their parents' alternate feelings of love, rejection, and overprotection—in short the internal reality—must be added to the external reality. The liabilities of over- and underplacement, the clash of the mother's and foster mother's possessive attitudes toward the child, his relations with foster siblings, are mentioned, and the sudden separation of mother and child versus gradual separation is discussed at length.

Transplanting a child from one human environment to another is a daily occurrence in child-welfare work. It is known that young

children fuss less when the separation comes as a surprise and when parents refrain from visiting for a month or so. Educators in charge often urge parents not to come, pointing to the obvious bad effect of parents' visits—the little ones clinging desperately to their parents and crying when leaving time comes, the upset of order and schedules. Anna Freud describes the disastrous effect of the sudden cutting of ties of affection and belonging. The child's grief may or may not be apparent—in every case the loss of attachments damages his mental health, if there has been no opportunity to anticipate and to adjust to the separation and to get acquainted with the person who is going to take the mother's place. It requires time and effort to form new bonds of love and trust with the parent substitutes.

In the meantime the child needs the parents' visits and the reassurance that they still care for him. The violent or mournful scenes at the parents' early visits are the child's way of digesting the fact of the separation. They are unpleasant for all concerned, they tax the patience of the foster mother, and upset the routine of the institution, and yet they are necessary. The authors go so far as to state that it is not the fact of the separation that wreaks havoc with the child (in some instances to the extent of producing psychotic symptoms), but its suddenness.

Throughout the book will be found observations and inferences likely to improve our understanding of children. To mention some: a child's mourning is often misjudged as "superficial" and not taken seriously because it is shortlived. "Mourning of equal intensity in an adult would have to run its course throughout a year."

Children can go apparently unharmed through experiences that would be harmful to adults. On the other hand, children may break down under strains that seem negligible to adults. Each age has its own methods of coming to terms with upsetting and painful events. For the adult, the outlet in conscious thought and speech acts as a "drainage for anxiety." This outlet was not accessible to the young children who had gone through actual bombing, through events of horror and bereavement. They never mentioned the scenes they had lived through; the events were apparently forgotten. After six months or even a year—*e.g.*, after the violence of the shock had calmed down—they began to talk about the bombing, and described what father and mother had done and said, all as if it had happened yesterday. These children did find an immediate outlet for their experiences in play and behavior. War games and attacks were staged without signs of fear, but with a great deal of unrestrained excitement.

Children have a far stronger tendency than adults to deny what is

unpleasant and disturbing in reality. A young child will always develop a strong tie with his immediate human surroundings. A mother may seem quite unworthy to the adult observer—her baby will cling to her just the same. Both traits may be considered a sequence of the child's entreme dependency on his surrounding, his inability to effectuate changes.

Workers in the field of foster care—institutional or family—will find a wealth of valuable observations and suggestions in the volume under review. In the residential nursery all children were at first cared for by all workers; later, children and workers were grouped into "artificial families" along the lines of preference shown by the children. The superiority of the new arrangement soon became evident: the children felt more secure, baby habits were given up, and there were significant gains in vocabulary. Social workers who observed the change of a consolidated institution to the cottage plan know of parallel results with older children.

In recent years the controversy over foster family versus institution has kept attention away from the possibility of developing institutions and of offering there to the children human attachments to-day provided neither by foster families nor by institutions. Anna Freud describes how her collaborators made every effort to include the parents in the residential nursery. Routine procedures and schedules were kept elastic to enable parents to come in at any time and to feed and bathe their child or to take him for a walk. This helped children and parents alike. The latter did not feel threatened with the loss of the child's affection. The residential nursery did what foster care should do, but seldom does—fill gaps in care and emotional attachment without usurping the child.

The second part of the book gives samples of reports. There are descriptions of ambivalent mothers and of mothers whose strong attachment to the child helped to bridge over bad shocks of separation and deprivation. There is a brief description of a child who re-lives the punishment meted out to him in a former nursery. He is unable to enjoy his dessert or to go to sleep with natural ease. The events are long forgotten, the misdeeds outgrown—yet he still reënacts in a compulsory way the conflicts and pains aroused by the severe punishment

The humorous side is not absent—for example, the contrast between the foolishness of human reactions—those of children as well as of adults—to danger and to little daily inconveniences. The description thereof, in the *Story of the Bomb Which Fell in the Garden Next Door*, is charming.

Readers who find the book instructive and thought-provoking may be interested to learn that Anna Freud and her collaborators con-

tinue to publish monthly reports, and that these are available to the general public through the Foster Parents Plan, New York City, in return for an annual contribution for the benefit of a needy British child. The authors have by no means exhausted their store of experiences in this book. Some of the reports of recent months have proved highly stimulating to the reviewer. Both book and reports strictly avoid technical language. Their vividness and warmth will be appreciated by advanced as well as by beginning students of child psychology and child welfare. In a new edition it will be possible to eliminate the printing mistakes that sometimes obscure the present text.

LILI E. PELLER.

Child Education Foundation,
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WOLF-CHILDREN AND FERAL MAN. By J. A. L. Singh and Robert M. Zingg. New York: Harper and Brothers, 1942. 379 p.

On October 17, 1920, Reverend Singh, an Indian missionary, captured two children who had been living with wolves not far from Calcutta. One of these, Kamala, was probably eight years old, apparently having been taken by the wolves in babyhood. She lived for nine years at the orphanage conducted by Reverend Singh. The other, Amala, perhaps eighteen months old, had been with the wolves long enough to be entirely strange to any human approach, and died a year after her capture. The first half of this volume is the day-by-day diary of the progress of these girls. In its own right the document is amazing in its simple clarity, its evident accuracy and restraint. Professor Zingg has studded its pages with voluminous and valuable notes.

In the last half of the book, Zingg has collected what is known of some thirty-odd feral men or cases of extreme isolation—including, of course, Casper Hauser. Painstaking attention to adequate annotation appears on almost every page. This is a most thoroughgoing collection of the valid data, with an excellent critique of the wide bibliography.

No review could do justice to the stirring account of the training and education of Kamala and Amala. The latter did not live long enough to make great progress, but Kamala's development, her widening vocabulary, the growing complexity of her sentences, her ability to solve "tests" of increasing difficulty, the slow emergence for her of a future and a past—this is good reading whether you are set for solemn science or for ripping adventure. Kamala always presented an "uneven" picture—*e.g.* that of a person who cannot use words, but is cunning beyond the ability of all of the adults of the orphanage

as to food, escape, and so on—but in a general sense she had advanced to about the three-year level by 1929, when she died.

One cannot similarly feel into the last half of the book, where the data seem fragmentary and unrealistic. This is true even in the case of Casper Hauser, despite the ninety pages of a translation of Von Feuerbach's excellent description and judicious criticism of the large number of titles on the subject. Many of the cases were unquestionably of very low mentality; the interest of the observers was in very different matters from those that now preoccupy us; even much of the terminology serves to make the material seem foreign. Perhaps also the "sameness" of the cases serves to blunt our interest. We are so much concerned with the problems of personality that it is baffling to encounter so many persons who seem to lack any sort of distinction. It remains, however, a great contribution to have brought under one roof the material on all that is known in this area.

The drama of the story compels us to return to Kamala and her little "sister." Is the account authentic? As Zingg says, it would seem "incredible that a humble Indian missionary could have invented so long an account, so consistent with material on other cases, most of which has never before been published in English." The twenty photographs play their part; there are attestations from officials of the district; but, as you read, the internal evidence of integrity is not to be denied.

Unquestionably much will be made of what we can learn from Kamala's development. Indeed, this has already started.[1] It does not detract one jot from the drama and interest of this story to point out that we have no parallel to such profound catastrophies as those that befell this girl. Reverend Singh saw this—as he saw so much else—in saying somewhere, "But we must not forget also that this girl Kamala is an artificial creation."

It is difficult to describe in words a faith and an implementation that deny the efficacy of words or techniques. The reviewer can only ask that you read the book to catch the deep meaning and worth of Mrs. Singh's massage. Communication of man's deepest feelings and highest hopes through the finger tips! For hours each day this was routine—and there was more of it for any crisis. We of the West grudgingly bow to the need of cuddling physical contacts for the small baby—and proudly claim our early emancipation. Mrs. Singh's ability to give and to evoke messages of the most fundamental importance make sobering reading for a word-centered culture. The

[1] See, for example, *Wolf Child and Human Child*, by Arnold Gesell (New York: Harper and Brothers, 1940), reviewed in MENTAL HYGIENE, Vol. 25, pp. 660–61, October, 1941.

reviewer feels that the volume's title might better have been *Two Indian Teachers*—and Professor Zingg seems to recognize this in the various passages in which he hopes that this work will lead to a monument to—"the Reverend and Mrs. Singh"!

Here is equally good reading for those who would know something of patience. Months go by with no apparent progress. Part of this patience is the Singhs' sense of the need for periods of the solidifying of gains—of recovery from too rapid change. Part of this patience is the Singhs' faith in what one might call the "ortho-tendency" of life. Those of us in therapeutic work can ill brook a contact or a recorded note without "progress." Is it not a matter of good fortune that there was not the compulsion to write a "case history" of Kamala—with perhaps a supervisor to help in evaluating the steps?

And there is more patience. Careful American Science asks whether Reverend Singh has X-rayed this or that, asks about post-mortems, waves its factual fist at the suppression of data because the two missionaries felt that they owed it to Kamala to hide her origin as being against her chances of marriage. Reverend Singh is quite as patient with young American Science as he is with young Kamala. There is only once when he must categorically write that an event actually occurred when American Science from the other side of the world had said that it couldn't.

For those interested in passive therapy, once more the book is recommended. Here is passive therapy in all its glory. Not one of its most slavish devotees but has much to learn from these two missionaries. If ever a person was allowed to grow rather than made to grow, Kamala was that person. If ever a worker consecrated himself to the finest sense of "how far the client is now able to go and wants to go," Reverend Singh was that worker.

The reviewer has tried—and, up to now, failed—to think of any one who could read this book without great profit and interest. Its lacunæ are sizable enough to allow the psychoanalyst great scope; and those interested in a simple account of what happened will revel in the story. In a way, it is too bad that the sheer drama of the events of the Midnapore Orphanage will outshine the outstanding contribution that Professor Zingg has made in the last half of the book. He, like Singh, is careful, patient, restrained, interested in what can be known actually to have happened. So many of the data of these other cases fit into the data of the diary that, without one's quite knowing it, this part of the volume greatly strengthens the story from India.

There is a great deal more to be said—but you will do better to read the book. You will not be disappointed.

JAMES S. PLANT.

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INFANT AND CHILD IN THE CULTURE OF TO-DAY: THE GUIDANCE OF DEVELOPMENT IN HOME AND NURSERY SCHOOL. By Arnold Gesell, M.D., and Frances L. Ilg, M.D., in collaboration with Janet Learned and Louise B. Ames. New York: Harper and Brothers, 1943. 399 p.

This is the latest and, in some sense, the summarizing volume of the long series of fundamental studies on child growth and development that have come from Yale's Clinic of Child Development under the direction of Dr. Gesell. It is addressed to "professional and lay workers" who deal with young children, including "parents as well as teachers, social workers, nurses, and physicians." The plan of the book makes it unusually effective in setting forth what may be expected of the young child at various points of growth and development with respect to several items of behavior. One could wish that every pediatrician and intelligent mother would read this book and realize to the full the damage that may be wrought by "cultural" pressure for achievements beyond the maturational level of the developing child.

Part I, of 64 pages, deals with growth and culture. Emphasis is upon the infant as an individual, living first in a family milieu, and then in an expanding environment of people, things, and activities. Possibly the keynote of this section is the statement that the preschool child "participates as a genuine member in cultural activities which are within his abilities."

Part II, of 214 pages, treats of the growing child. This is the section of greatest practical importance to parents, doctors, and teachers. Here are presented for each of twelve different ages, from four weeks to five years, a "behavior profile" and a "behavior day." What about the sleeping, feeding, elimination, bathing and dressing, self-activity, and sociality of the sixteen-weeks-old infant—or of any of the other stages? The answers are found in detail at this point in the book. Average normative development and behavior are clearly and simply described. Many a wrong idea about the introduction of foods, toilet training, and the like could be corrected and pernicious effects obviated if child-guidance workers would help to spread these facts.

Part III, of 77 pages, expresses a philosophy concerning the guidance of growth. A chapter on the growth complex re-surveys the data about sleep, feeding, and so forth, as they develop and vary at the various age levels considered.

An appendix describes the Yale Guidance Nursery, and gives lists of toys, play materials, books, musical recordings, and so on. There is a short list of selected reading and an adequate index. The end papers, photographs of stages of development, are especially charming.

This book deserves a preferred place on the reading list of all pro-

fessional workers with small children. Certainly, if its material can be got across to parents, numbers of them who now have "many an ill-founded anxiety" would be enabled "to enjoy" their children.

LAWSON G. LOWREY.

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SOCIAL NORMS AND THE BEHAVIOR OF COLLEGE STUDENTS. By J. Edward Todd. New York: Teachers College, Columbia University, 1941. 190 p.

Using many types of research procedures, ranging from the carefully documented social analysis of the historian to the group tests of the psychologist and the case study of the social worker, Dr. Todd presents an analysis of the pattern of American culture and its influence on college students.

His analysis of our social values leads him to conclude that "the successful businessman with his capitalistic philosophy of rugged individualism and private gain in free competition occupies the place of leadership and typifies the common ideal of America. Near him stands the politician who gains power through political maneuvering in government or business. Next is the scientist who is recognized as being a useful servant of the other two. The labor leader and social worker are making places for themselves. The clergyman who was earlier respected is now politely ignored. The artist is achieving more recognition after long passing unnoticed."

As is to be expected, this cultural picture is reflected in the personality patterns of college students. When the Allport-Vernon study-of-values test was given to secondary-school students before they entered college, the results showed that "most of them were more concerned with personal power, influence, renown, the accumulation of tangible wealth, the utility of ordered and synthesized knowledge than with religion, people, or the artistic aspects of life. Exceptions to these general emphases appear . . . but several approaches . . . bring consistent evidence that such a pattern of values exists among students as they finish high school."

When the same students were retested after having been at college for a year, Dr. Todd found the pattern of values "to be almost unchanged although there were some shifts in emphasis."

An interesting part of this study consists of the detailed case studies of six young men who were selected by the investigator as representing the personality types described by Spranger. They were chosen because they were the boys who had received the highest scores on each of the six Allport-Vernon study-of-values scales. Dr. Todd is thus able to present a fuller picture of the students he labeled as The Theoretical Student, The Economic Student, The

Æsthetic Student, The Social Student, The Political Student, and The Religious Student. Use of the case-study procedure enables the author to show how the student's family and social background influence his personality pattern, as well as to indicate the effects that participation in college life has on various types of student. An indirect evaluation of the modern college is seen in the fact that only The Religious Student, The Social Student, and The Theoretical Student made good adjustments to college. The Æsthetic Student and The Political Student made less satisfactory adjustments, and The Economic Student failed to remain in college the first year.

Dr. Todd's report is a good demonstration of the way in which individual case studies and group tests of personality traits supplement each other. The group test is a quick and relatively inexpensive way of discovering the students who need individual analysis, but the paper-and-pencil measure of personality, used alone, is inadequate.

To be sure, any study of the cultural scene or of personality patterns that sees only six personality patterns is incomplete. The use of types in this report is most helpful when we see them as suggestions of the ways in which different kinds of student react to the society in which they live and to the college they attend. Moreover, one year at college is too short a time in which to expect any significant changes in attitudes. It is demanding too much of the college to expect it to change in a matter of months attitudes that young men have been forming over a period of eighteen years. We hope that Dr. Todd will find it possible to follow his cases for a few years more, to see whether four years at college have a more noticeable effect on the students' values.

HARRY N. RIVLIN.

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THE RELATIVE IMPORTANCE OF FACTORS OF INTEREST IN READING MATERIALS FOR JUNIOR HIGH SCHOOL PUPILS. By Dale Zeller. (Contributions to Education, No. 841.) New York: Teachers College, Columbia University, 1941. 89 p.

This volume presents a statistical approach to the determination of interest factors in children's reading materials. Forty-eight books were rated by four thousand junior-high-school students. Eight judges estimated the extent to which eighteen interest factors were present in these same books. Books well liked by boys were rated by the judges as high in factors of action, adventure, combat, rivalry, contrasts, sensational situations, appeal to the senses, and humor. Analysis shows that the first five of these factors represent a single factor under different names. Books well liked by girls are rated by the judges as high in factors of humor, people, familiar experience,

situations in which readers can imagine themselves, happy ending, and plot. Except for humor, these factors are different from those that attract boys. A chapter is devoted to regression equations for the prediction of interest by the statistical weighting of these factors as estimated by adult judges.

The procedures and analyses throughout this study are clear and ingenious. It is doubtful, however, that the regression equations provide an incisive tool for the prediction of interest values. The predictions are too mechanical and are necessarily a step removed from the reality of children's reactions. We need more research refining the direct measurement of children's likes and dislikes. The low correlations between the two criteria of interest value employed by Dr. Zeller illustrate a crucial problem at this point. When frequency and preference ratings correlate only .41 and .36, it should be clear (1) that one or the other is not a valid measure of interest and (2) that a composite of the two measures is indefensible.

The larger need is for an extensive list of accurately graded and attractively annotated books that are genuinely interesting to children and that meet certain minimum adult standards of literary excellence and content value. Having labored at these problems (see Genetic Psychology Monographs, No. 11, not cited by Dr. Zeller), this reviewer appreciates the difficulties involved. The difficulties are technical and practical. The first involves a series of intensive studies of selected books for the purpose of developing and validating techniques and procedures. The second involves the large-scale application of the tested techniques to the entire range of children's recreational reading.

While librarians continue to issue excellent reading lists, the quality of research on these problems has been appallingly low in recent years. The several studies are obviously too big for individuals. The American Library Association should assume the leadership in stimulating both intensive and extensive researches and in integrating these with the accumulated practical wisdom of librarians who know children and children's books.

FRANK K. SHUTTLEWORTH.

College of the City of New York.

LANGUAGE HABITS IN HUMAN AFFAIRS: AN INTRODUCTION TO GENERAL SEMANTICS. By Irving J. Lee. With a Foreword by Alfred Korzybski. New York: Harper and Brothers, 1941. 278 p.

Language mechanisms as well as their uses are extremely complicated phenomena, and a great many books have been written about this special integration, the details of which are not well known. Language is an essential part of human activity, serving as a medium for understandings, and too often for misunderstandings in the

everyday life of persons who have been born into the more or less set patterns of this medium.

Organized language differentiates the human being rather completely from the other animals. From the beginning the growth of language has proceeded without plan or forethought, but its function is the attempt to convey, to preserve, and to promote ideas as accurately as possible and to make these ideas as generally understandable as possible. Our ideas are understood by others when we convey them in words the meaning of which is understood by others.

Words are the symbols of experience, having a long past history of functions. On the way they have undergone evolutional changes, physiological modifications, and not a few pathological distortions. There is still more to come to the surface, in some way, since the body is as yet incapable of expressing all of its wisdom in gestural, in spoken, or in written symbols. There are still many languages or forms of language in the body, and revealed by it, that we are unable to read or to interpret or even to recognize as manifestations.

This book by Dr. Lee describes the science of the use of language. It is based largely on the teaching of Count Alfred Korzybski and deals with many of the essentials set forth in his book, *Science and Sanity*. It is one of the representatives of a sound constructive effort that is under way to correct some of the diseases of language. "Students who read this book carefully should get (1) a sense of the problems and difficulties involved in making accurate statements about themselves and the world in which they live, and (2) a sense of the maladjustments both personal and social that have their roots in improper evaluation because of false-to-fact language habits."

In many books of this general type, the good stuff is so swamped or buried in an overgrowth of verbiage that the reader develops "cerebrasthenia" in making his mental excavations. In this book, however, the subject is presented in simple, common-sense, practical language, enlivened by numerous examples which aptly illustrate the points under discussion. By the use of the methods described, thinking should become more flexible, more objective, and more realistic as the relationship between words, thoughts, and facts is discovered and evaluated. This will make for precision in work, for a more scientific use of terminology, for the elucidation of problems of cause-effect relationships, and for a consciousness of the orders of abstraction.

The methods of extensional analysis used in general semantics could be utilized with profit in the field of mental hygiene, where they should have a favorable effect in the psychoneuroses and in the early stages of some psychoses in which muddled thinking characterizes the nucleus of the disorder, but their efficiency when applied as psychotherapy for the treatment of full-blown mental disorders does not

seem to have been established, and more facts are needed. A more efficient communication between the psychotherapist and the patient is certainly desirable.

The book could be used to vitalize college courses in logic, philosophy, psychology, and pedagogy, as it shows how to make premises clear and how to tell what happens as exactly as possible. Although it was intended as an introduction to the subject, it contains enough thought-provoking material to keep a reader, and particularly a thinker, occupied for some time. It could be read with profit along with Hayakawa's *Language in Action* and I. A. Richards' new book, *How to Read a Page.*

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MENTAL HYGIENE FOR COMMUNITY NURSING. By Eric Kent Clarke, M.D. Minneapolis: University of Minnesota Press, 1942. 262 p.

There can be no better, briefer statement of the purpose of this book than Dr. Clarke's own introduction to his subject:

> "The community nurse is in a strategic position to do constructive work in mental hygiene. She has access to homes at all times, for the treatment of people of all ages. Her chief concern is with physical health and for this she has been trained. But the community nurse in her daily work also encounters manifestations of mental deviation whose significance she frequently fails to appreciate. Conditions are allowed to persist that, if recognized early, could be successfully eliminated before the pattern became firmly established. Treatment procedures would often be simplified and shortened, for in many cases the complaint of ill health covers an underlying disturbance of emotional integration. Little improvement can be expected as long as psychic factors are ignored. . . . Our aim is to enable the community nurse to recognize and report the emotionally needy case for study at an early period when treatment can be most effective."

This, then, is not "another textbook in psychiatry," but an attempt to offer concrete suggestions to nurses for the handling of the most common types of problem encountered in her daily rounds. The first chapters take up familiar problems under age groupings; the later chapters cover some of the more usual evidences of psychoses and discuss the community facilities for treating them. Throughout, the approach is positive and constructive. A well-selected, annotated list of reading references supplements each chapter.

The book is rich in illustrative case material and will be found clear, simple, and honestly helpful to public-health nurses who have

not had the benefit of special psychiatric training. For those with special training, it will be elementary. Chapter XI, *The Mental Hygiene of the Community Nurse,* offers some very timely and frank advice which we as a group ought to be able to "take" and apply to ourselves, in spite of the fact that Dr. Clarke scores several painful direct hits on us as professional workers.

Dr. Clarke makes a very urgent plea to nurse educators for the inclusion of better fundamental preparation in the care of the mentally ill and potentially ill—a plea in which every public-health nurse would heartily join.

DOROTHY DEMING.

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ALCOHOL ADDICTION AND CHRONIC ALCOHOLISM. Edited by E. M. Jellinek, for the Research Council on Problems of Alcohol. New Haven: Yale University Press. 336 p.

This book constitutes Volume I of a series of three volumes on the effects of alcoholism on the individual. It consists of two parts. Part I contains a chapter on alcoholic addition and its treatment and one on alcoholic mental disorders, both by Karl M. Bowman and E. M. Jellinek. Part II is made up of four chapters: *Vitamin Deficiencies in Chronic Alcoholism,* by Norman Jolliffe; *Alcoholic Encephalopathies and Nutrition,* by Norman Jolliffe, Herman Wortis, and Martin H. Stein; *Marchiafava's Disease,* by Giorgio Lolli; and *Cirrhosis of the Liver,* by Norman Jolliffe and E. M. Jellinek.

The object of the authors in the preparation of this volume was to analyze the results of researches on the topics treated. Several thousand books, pamphlets, and special articles were examined, analyzed, and evaluated. The opinions of psychiatrists, whom the authors regard as authorities, are cited at length. Only a small part of the book is the outcome of the authors' personal experience or study.

Throughout the book, there seems to have been a desire on the part of the authors to minimize the injurious effects of alcohol. In common with many psychiatrists, they hold that alcoholic addiction and alcoholism are due primarily to personality defects or deviations which cause individuals to resort to alcohol as a means of escape or compensation. Likewise they demonstrate to their satisfaction that in many cases of alcoholic mental disease, the disease arises from vitamin deficiencies rather than from consumption of alcohol.

In reading Chapters I, II, and III, one is led to the strange, almost absurd, conclusion that in alcoholic addiction, alcoholism, and alco-

holic mental disease, alcohol is after all not much of a problem, and that these disorders are chargeable to personality defects or disorders and vitamin deficiencies.

The authors of the book have performed a useful service in bringing together a great many opinions and some excellent descriptions of various types of so-called alcoholic disorders. That the book makes a contribution to the solving of the problems of alcohol, is doubtful.

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THE IMPULSE TO DOMINATE. By D. W. Harding. London: George Allen and Unwin, 1941. 256 p.

This author sees war as a violent form of the process of coercion which he believes is the means whereby all conflicts in society are solved. In so far as domination and submission constitute the normal pattern in private life, the ordinary citizen cannot avoid acquiesing in war in the settlement of stubborn conflicts with other nations. The thesis will disturb many, and they in particular should give the book careful study.

The author emphasizes the "remarkable cohesion of every warring nation," and discusses the methods by which the individual citizens come to join in the national effort and sacrifice involved in war. He disposes of a "very large proportion" as being swayed by relatively crude propaganda, those who "have an understanding of national affairs which is fairly comparable to the ten-year-old's grasp of his family's affairs." His comments on the "churchmen and academics" and how they fall into line are of particular interest:

> "All through their professional lives they have built up habits of compromise, rules for tempering enthusiasm, conventions of drawing the line, which serve to maintain a pseudo-reconciliation between certain of their ideals, often hostile to the established social order, and their respected positions within that same order. It is this background which enables them in time of war to give that sincere support of the national effort which alone ensures their continued centricity."

In his discussion of the relation of unconscious emotional factors to war, he raises some very pertinent and challenging questions as to psychoanalytic theories of aggression. Regarding emotional changes manifest in the individual during war, the chapters on cruelty and on sexual interest are of particular interest in reference to the loosening of peace-time standards that occurs in war time. Thus, in regard to atrocity stories, he comments on the extraordinary interest that so many civilians show in avidly imagining and denouncing the brutal acts of which they read, and he recalls the readiness with which in World War I they accepted such stories, many of which proved to be

exaggerations, if not deliberate falsifications. In regard to the apparent increase in sexual freedom and expression that occurs, this reveals, he suggests, that the precarious sexual standards of peace time must have been sustained by threats and repression rather than by conscious choice.

The chapter, *Protest and Collapse,* is worth reading by all for its discussion of the problem of counteracting the weakening of purpose and enthusiasm inevitable in a long war. If a nation staves this off during a war, it often becomes manifest in the post-war period, as occured after World War I, when people said that the war had been a mistake and without purpose or justification. This kind of let-down may lead to the situation that has been described as "winning the war and losing the peace." The quotations from the memoirs of Sassoon give the skeleton of an excellent case study, showing how this sequence of events may occur in the individual.

The author goes on to discuss how far we can build up political barriers against war. For those who believe that society operates on a domination-submission basis, the solution can only be "a monopoly of coercion in the hands of some élite." The alternative would be a process of "integrative education," but the author recognizes the limitations of such an effort. He talks of a more integrative texture of society, based on a "heightened social responsiveness," which would make us accept the social importance of others in respect of their own rights and not only because they help or hinder our ends. He distinguishes this from the sentimental social responsiveness that in a dominative society expresses itself only toward the weak and helpless, children, cripples, and paupers. Then he proceeds to discuss the ways and means whereby we might set about attempting to produce the changes that appear necessary in the individual and his social relations if we are to relinquish war in the future.

In a concluding chapter, he gives an excellent summary of his argument. This can be recommended for those who have no time to study the work as a whole, and might stimulate an interest in finding the time to do so. The book can be highly recommended to all who are interested in human relations and in the future of mankind, to professionals and laymen alike, and it should be in the hands of all who are concerned with winning the peace as well as the war.

DAVID SLIGHT.

University of Chicago.

NOTES AND COMMENTS

Compiled by

MARY VANUXAM

New York State Committee on Mental Hygiene of the State Charities Aid Association

National Committee Establishes a Division of Rehabilitation

In view of the growing need for rehabilitation services to men rejected or discharged from the armed forces, and in view of the possibility that the mentally handicapped may now be included in the Federal rehabilitation program, The National Committee for Mental Hygiene has established a Division of Rehabilitation, under the direction of Dr. Thomas A. C. Rennie, of the Payne Whitney Psychiatric Clinic, New York City. It is planned that this Rehabilitation Division shall act as a point of clearance in the field of rehabilitation and a source of advice to those responsible for the official Federal rehabilitation program.

New York Hospital Initiates Rehabilitation Clinic

A psychiatric rehabilitation program, which it is hoped may point the way toward reclamation of the estimated 80,000 New York City men thus far rejected or discharged from military service because of mental illness, has been launched by the New York Hospital Payne Whitney Psychiatric Clinic at the New York Hospital. The program is the first private-hospital psychiatric project for service men to be put into operation in the metropolitan area, and interest in it has been shown by state Selective Service officials and social-service agencies throughout the city.

Recognizing that the thousands of men who have proved unsuitable material for the army, the navy, and other services because of psychoneurosis constitute a tremendous war-time emergency problem which will exist and grow even after the war, the hospital has established a special out-patient clinic that is already functioning, and the full resources of the New York Hospital Payne Whitney clinic will be devoted to patients' rehabilitation. The integration of psychiatric treatment with the psychological testing, retraining, and employment resources of an actual community is to be emphasized in the program.

Originators of the plan are Dr. Thomas A. C. Rennie, attending psychiatrist at the Payne Whitney Clinic and associate professor of psychiatry at Cornell University Medical College, who will direct the program, and Mrs. Melly Simon, chief of psychiatric social service at Payne Whitney. Dr. Rennie was recently named Director of the Division of Rehabilitation of The National Committee for Mental Hygiene. Basic funds to start the clinic have been granted by the Commonwealth Fund.

Commenting on the need for rehabilitation, Dr. Rennie said that the whole program of psychiatric rehabilitation of discharged and rejected service men has loomed up in New York City, as well as throughout the nation, as a tremendous challenge. He pointed out that psychiatric casualties constitute from 28 to 35 per cent of all men discharged from the army, and that many of these are likely to become chronic problems and lifetime responsibilities of the government. "In World War I," he said, "the average cost of each psychiatric casualty to the government was $60,000 and the total cost was almost a billion dollars, while the loss in human material was incalculable. Many of the same type casualties of the current war can be rehabilitated and the sooner treatment can be instituted, the more likely will be their chances for recovery. It has sometimes occurred that men honorably discharged from or rejected for military service for psychiatric reasons have found it difficult to secure employment once this fact is known, and the resulting strain and uncertainty frequently aggravate their condition. While it is doubtful whether these men could be made available again for military service, because of the danger of recurrence of their maladies under the strain and pressure of military life, unquestionably a considerable proportion of them can be rehabilitated to perform highly useful work in essential industries."

Dr. Rennie stated that the clinic is staffed by New York Hospital psychiatrists, psychoanalysts, and social workers, all of whom are serving on a voluntary basis, and it is expected that before many weeks fifteen or more such voluntéer psychiatrists will be actively at work. In addition to this New York Hospital volunteer staff, other psychiatrists in the city have signified their willingness to participate in the same kind of projects.

Among outstanding social-service agencies who have evidenced their interest and willingness to coöperate with the program are the New York City Committee on Mental Hygiene, The National Committee for Mental Hygiene, the Social Security Board, the U. S. Employment Service, the Vocational Adjustment Bureau, the American Rehabilitation Committee, the Community Service Society, and the

Y.M.C.A. Arrangements have also been made for the reference of cases to the clinic by the state Selective Service board.

"The clinic," Dr. Rennie said, "will fulfill two main functions: (1) as an actual treatment center for men in need of total over-all service in their own rehabilitation and (2) as a fact-finding agency to determine the extent of the problem, the amount of help necessary for rehabilitation, the nature of psychiatric disabilities, and what percentage of the patients treated may eventually be reëmployed. Such kinds of fact may ultimately be of value in orienting Federal authorities in their war and post-war rehabilitation planning."

Rehabilitation of the Mentally Handicapped

On July 6, 1943, President Roosevelt signed House Resolution 2536, whereby it became Public Law No. 113, 78th Congress. This law for the first time opens the way to the rehabilitation of the mentally handicapped. The bill was introduced by the House Committee on Education as its own bill after consideration of many earlier bills, none of which arrived at a point of vote by Congress. This is true both in our present and in previous Congresses. This bill was passed on June 10, and on June 22 it was passed by the Senate with 30 amendments. After conferences between House and Senate, Congress finally passed the bill on June 29, 1943. The amendments eliminated certain desirable features of the bill as originally written. One of these would have authorized agreement and coöperative working arrangements with public and private agencies. This provision would have been of value in the case of the mentally handicapped since there is such scant public experience in this field and so much need for research and experimentation that advantage should be taken of collaboration with other agencies that have provided rehabilitation for the mentally handicapped. As reported by the Council on Rehabilitation:

> "Generally, the Act proposes no fundamental change in the principles and objectives of the vocational rehabilitation program under the Act of June 2, 1920, which it replaces. It corrects many inadequacies, particularly in the matter of the provision of physical restoration, maintenance while undergoing training, and removal of the restrictive provision of a maximum amount which the Congress may appropriate for carrying out the purposes of the Act. Except in the case of the cost of furnishing rehabilitation services to war-disabled civilians, and the expenditures of the states necessary for the proper and efficient administration of the state plans which are borne entirely by the Federal Government, the cost of the program is borne by the Federal and state governments on a 50–50 basis. There is provision that, in the case of any state found by the Federal Security Administrator to have substantially exhausted its funds available for the necessary expenditures of the

> program during periods prior to July 1, 1945, increased allotments may be apportioned by the Administrator under general regulations promulgated by him.
>
> "Provision is made in the Act for providing medical examinations to applicants, without cost to them, where necessary to determine eligibility for vocational rehabilitation, the nature of rehabilitative services required, or occupational limitations."

This second paragraph is highly important, for the mentally handicapped are especially in need of medical examination on an extramural basis. Hospitalization and hospital treatment in this Act have been limited to the physically handicapped, but this is not a great disadvantage since, state by state, these services have already been provided in our state hospitals. Extramural diagnostic service is not so widespread, is much needed, and would seem to be possible under this law.

The report of the Council on Rehabilitation continues:

> "Differing from the old rehabilitation law (Act of June 2, 1920, as amended), the new Act gives no definition of 'disabled individual.' It defines the term 'vocational rehabilitation,' and the term 'vocational rehabilitation services,' as used in the Act, as 'any services necessary to render a disabled individual fit to engage in a remunerative occupation.' With no specific definition of the term 'disabled individual' written in the Act itself, it is possible that it may be construed to include the extension of vocational rehabilitation services to those who may have mental disorders or involvements susceptible through treatment of such a degree of correction as will render them fit to engage in remunerative employment. This is a matter that will have to have administrative interpretation.
>
> "The Act provides also for transportion, occupational licenses, tools, textbooks, and other necessary materials for instruction, and the maintenance of the beneficiary while undergoing training, not to exceed the estimated cost of subsistence.
>
> "It is of importance to note that, except in the cases of war-disabled civilians, the services of physical restoration enumerated, and the items of transportation, occupational licenses, tools, textbooks and other necessary training materials, and maintenance while undergoing training are provided only in the cases of disabled persons found to require financial assistance with respect thereto, after full consideration of the eligibility of such persons for any similar benefits by way of pension, compensation, or insurance."

This law provides for a 50–50 sharing of the costs of rehabilitation between state and Federal governments. The state must take the initiative in formulating the program and submitting it to Washington. It would seem highly important at this time for the state authority of the mentally ill to get in touch with the Rehabilitation Commission in order that state programs may include service to the mentally handicapped and possibly also psychiatric and psychological services to the physically handicapped.

If the state rehabilitation commission, in close coöperation with the mental-hospital authority, could develop a facility whereby the patient discharged from the mental hospital who has difficulty in finding employment could receive assistance, it might have important influence in reducing the number of relapses.

Social Workers in Army to Receive Classification

During the past year the American Association of Psychiatric Social Workers and The National Committee for Mental Hygiene have given their assistance in the development of a plan for the classification of social workers in the army. Under conditions as they have been, a social worker entering the army has lost his professional identity because at the time of classification there has been no place on the list for him. When needed to function in connection with a mental-hygiene unit, he has had no official existence and there has been no way of finding him. Army Classification Number 263 now describes the social worker and covers the military job of psychiatric social worker. For the first time in history, the army may draw on trained social workers in uniform to perform an army social service, a service that is essential to the early diagnosis and treatment of psychiatric cases.

Army Classification Number 263 stipulates that the social worker should have had at least two years of supervised experience in a public or private agency performing all or a major part of the above (social case-work) activities; or graduate work with a degree in social work granted by a recognized school of social work will satisfy the experience requirement.

At the time of induction, a soldier may now have his civilian occupation of social worker listed if he meets the qualifications, and he may request assignment as a psychiatric social worker with a psychiatrist in a clinic or a hospital unit. If he is already in the army and not an officer, he may apply for reclassification. As yet there is no prospect of his being commissioned as an officer for service in this specific field.

This possibility of reclassification might well be called to the attention of men eligible for Classification Number 263.

War-time Program Stressed in Report of National Committee for Mental Hygiene

The seven-point program in which The National Committee for Mental Hygiene has formulated its war-time tasks is the main theme of the Committee's annual report, recently issued. The seven points are:

"1. Exclusion of the mentally unstable from the armed forces and their employment in fields of civilian usefulness.

"2. Early detection and treatment of incipient neuropsychiatric cases within the armed forces and prompt and adequate care and disposition of the mentally ill.

"3. The rehabilitation of mentally disabled civilians and service men, both to augment man power and to assist in individual adjustment.

"4. Continuance of civilian services for the mentally defective, unstable, or ill.

"5. The maintenance of public morale.

"6. Mental-health guidance a stringent necessity for civilians transferred to new environments and those dislocated by change of occupation.

"7. The need of strengthening mental-hygiene services in order to meet the challenge of post-war life in America."

Taking up each of these points, the report describes the steps that are being taken to put it into effect and the further measures that are needed.

While admitting that conditions in the war-torn world of to-day offer the greatest challenge that the National Committee has ever been called upon to face, the report strikes a note of confidence and courage. It draws a parallel between our times and that other dark and bloody period of turmoil and upheaval in France one hundred and fifty years ago—"when the gutters of Paris flowed with blood, when violence and terror stalked the streets, when the air resounded with the cries of the doomed on their way to the guillotine." Yet "in that same year, in that same city, an epochal event of a very different character took place—an event which consisted not in violence, but in the sudden abrogation of violence"—the striking off of the shackles from the insane in the Bicêtre by Philippe Pinel.

"The present world-wide cataclysm dwarfs in importance even the French Revolution," the report continues. "But The National Committee for Mental Hygiene is determined that out of this cataclysm shall be born as great an advance in mental hygiene as took place when Pinel went calmly and steadily about his work in the midst of that other upheaval. In all probability the new advance will be in the direction of prevention, but we resolve that, whatever its direction may be, the progress, although perhaps less spectacular, shall be no less epochal than the great transformation effected by Pinel in the treatment of advanced cases."

In addition to the war-time program, the report contains also brief accounts of the work of the Committee's various divisions during the year and the treasurer's statement.

A limited number of copies of the report are available for distribution. Any reader of MENTAL HYGIENE who wishes to secure one

can do so by writing to the Committee's offices, 1790 Broadway, New York 19, N. Y.

Psychiatry and the Armed Forces

The following report on the existing situation as regards psychiatry in the armed forces has been sent to the members of the American Psychiatric Association by Dr. Edward A. Strecker, president of the association:

"As you know, the Psychiatric Divisions of the army, navy, and public-health services are staffed and administered by fellows of our Association: army, Colonel Roy D. Halloran and Lieutenant Colonel Malcolm J. Farrell; navy, Captain W. F. Kennedy, Commander Francis J. Braceland and Lieutenant Howard P. Rome; U.S.P.H.S., Daniel Blain, Surgeon (R).

"I have had the satisfaction and the pleasure of calling on the new surgeon general of the army, Major General Kirk. He assured me of his recognition of the importance of psychiatry and of the need of the army for an adequate psychiatric service. He favors the utilization of divisional psychiatrists, which, on the basis of our experience in World War I, is a sound principle. The surgeon general is favorably disposed toward occupational therapy and he is hopeful that it may be utilized on a wide medico-military front. . . .

"By virtue of my position as consultant in psychiatry to the Bureau of Medicine and Surgery, U.S.N., I am given the opportunity and the privilege of conferring frequently with Surgeon General McIntire and his staff. Considering the great diversity of medical problems in the navy, Surgeon General McIntire is amazingly accurately informed, and to every psychiatric problem he gives capable and sympathetic understanding. The psychiatric staff of the medical department of the navy has formulated a comprehensive plan, ably conceived and, in spite of many obstacles, particularly in the overseas theaters of war, the plan is being satisfactorily executed.

"As consultant to the army air forces, I have had the opportunity of assisting in the formulation of a plan designed to meet the psychiatric needs of the army air forces. These needs raise problems which are relatively new in military medicine, and in my opinion, general army medical experience has only a limited application in their solution. . . .

"As reports come in from all the services overseas, it becomes increasingly evident that this global war is probing depths of human emotions hitherto rarely touched and that there are repercussions in the clinical shape of very acute and very recoverable psychotic and psychoneurotic personality disruptions.

"On June 25, 1943, in Washington, at the luncheon invitation of Mr. Eugene Meyer, Editor of the *Washington Post*, Dr. George Stevenson, Dr. Marion Kenworthy, Miss Marion McBee, Colonel Halloran, and I were given the opportunity of meeting John J. McCloy, Assistant Secretary of War, and discussing with him the important question of earmarking at induction—or reclassifying those already in the service—the psychiatric social workers who are so much needed in the psychiatry of war. The assistant secretary of war received favorably the plan that

was presented and was inclined to believe that it could be brought to accomplishment.

"A serious situation exists in regard to trained psychiatric male nurses —serious for the armed services and serious for civilian psychiatry. Unless corrective steps are promptly taken, our schools for the training of young men who wish to become psychiatric nurses will have to close their doors, since deferments are not granted in this field. A feasible plan is proposed: That the army and navy take over the schools in much the same way that they have taken over the medical schools; put the men in uniform and pay them at the usual rate of $55 a month with the customary allowances. Since the men would already be in the army or navy, they would immediately, upon satisfactory completion of the course of studies, become helpful to the medical services in a service for which there is an immediate and pressing need. The training schools are not many; the number of men involved is few, and there is no threat to military man power.

"In pursuance of this worthy objective, many conferences have been held with the military authorities and with civilian experts: Dr. Raymond Waggoner, newly appointed Director of Psychiatry, Selective Service, is interested and anxious to be helpful; Dr. Fitzpatrick and the A.P.A. Nursing Committee are doing everything they can; Mrs. Laura W. Fitzsimmons is giving close attention to this highly important consideration. I earnestly urge every member of our association to put the weight of his influence into the satisfaction of this need, which will mean so much to the men who become disabled by the psychic wounds of war. . . .

"I am privileged to convey to you directly messages about a matter of extreme importance and of the greatest urgency: *The need for more psychiatrists in the armed services.*

"From Colonel Halloran for the army: '(1) There is an urgent need for additional psychiatrists for the army since there is at the present time an insufficient number of adequately trained psychiatrists to meet current military needs. (2) Certain vitally necessary psychiatric services are contemplated which will require additional qualified psychiatrists. (3) In spite of a much tighter screening process than that used in the last war, the psychiatric problem remains a very important one. There is an urgent need for the services of competent civilian psychiatrists who can contribute to the psychiatric preventive program and to the care and management of neuropsychiatric casualties. (4) There is a distinct challenge to psychiatry and psychiatrists at the present time. With proper application of well-known principles, the results of the psychiatrists' efforts are immediately apparent. (5) Every physically qualified psychiatrist, especially those in the younger age group, who can be spared from his present duties, is urgently needed by his country.'

"From Captain W. F. Kennedy for the navy: 'There is a pressing need for psychiatrists for duty with the U. S. Navy at the present time. The navy is desirous of obtaining men with neuropsychiatric background, particularly those who have one or more years of neuropsychiatric training. Commissions are awarded on the basis of age, academic seniority, and professional qualifications, and all men who are qualified neurologists and psychiatrists are being placed in neuropsychiatric billets. Any one who is interested may obtain complete details by writing to the Bureau of Medicine and Surgery, Navy Department, Washington, D. C. There

are many interesting facets of psychiatric work in the naval service, ranging from duty in training stations on the mainland to interesting psychiatric work in the far-flung bases.'. . .

"I am deeply conscious of the fine, unselfish service being rendered to the civilian population by psychiatrists who are bearing the doubly hard burden of civilian service. Our stimulus is that the future of psychiatry as a free science is at stake in this war."

A Mental-Hygiene Program at a Replacement Training Center

The neuropsychiatric program established at the Anti-aircraft Replacement Training Center, Camp Callan, California, over a year ago, envisioned a twofold function: "(1) the detection and proper disposition of the neuropsychiatric misfit; and (2) the prevention of serious personality disturbances (as well as a positive contribution to morale) by assisting the soldier to understand why he is fighting."

This latter objective has been sought through a nine-point mental-hygiene program, which includes the following activities: (1) psychiatric orientation courses for officers, social workers, and non-commissioned officers (six lectures three times a year); (2) a mental-hygiene talk to each new battery (second week); (3) orientation movies and talks; (4) battery classes in citizenship and war issues; (5) daily news broadcasts—interpretation and counter-propaganda; (6) a weekly discussion forum on war issues, current events, and camp-life problems (attendance voluntary); (7) a weekly newspaper column; (8) posters and cartoons; and (9) talks to civilian groups in neighboring communities on psychiatry and war.

A detailed analysis of three of these nine activities—the psychiatric orientation courses, the mental-hygiene talks, and the classes in citizenship and war issues—has been prepared by Major Julius Schreiber, M.C., neuropsychiatrist in charge of the program, and reproduced by the Josiah Macy, Jr., Foundation, of New York City, for distribution by The National Committee for Mental Hygiene. Copies can be obtained by writing to the Committee's offices, 1790 Broadway, New York 19, N. Y.

Nurse Cadets

Dr. Robert Woodman, of The National Committee for Mental Hygiene, has sent the following letter to superintendents of all state hospitals for mental diseases, a few selected county and municipal hospitals, all state societies for mental hygiene, and state-hospital boards and state departments of mental hygiene:

"Under the Bolton Act, approved June 15, 1943, (a copy of which may be obtained from your Congressman) and regulations of the

Surgeon General, U. S. Public Health Service, promulgated thereunder on July 9, 1943, important changes are made in the status of many thousands of nurses under training. It is proposed that 'senior cadet nurses,' as they are to be called, in the last six months of their nursing course, before becoming eligible for graduation will be separated from the hospital schools where they already have had twenty-four to thirty months' instruction as pre-cadet nurse and junior cadet nurse, and assigned elsewhere to finish their theoretical and practical work. This gives an important opportunity to the mental hospitals, if some initiative and energy and a moderate amount of money are thrown into the situation to meet the standards of the surgeon general and of the appropriate accrediting agency for schools of nursing, information on which may be obtained by writing to the U. S. Public Health Service.

"The regulations specify that local boards of nursing examiners are to pass on the details of the arrangements made. They must approve the training program that is set up in the institution that will take these students for the last six months of their training. Certainly in most states they are sympathetic to the new arrangement. It is not expected that the educational set-up will be equal or similar to that of the last six months of the parent school in normal times, but it must be sound as far as it goes.

"Institutions not usually conducting a training school for nurses could become eligible to receive such senior cadets by providing one or more instructors who can give supervised experience which will be credited towards graduation, furnishing satisfactory quarters, properly supervised living conditions, and paying them 'not less than $30.00 per month.' Any mental institution that can properly call itself a hospital has nurses in its organization who can do some teaching. Moreover, there are still in our communities older experienced nurses who might be called upon for some instruction. No one person will have to do it all. Two or more names are better than one. It seems to be an opportunity to enlarge our nursing services and improve their standards at small expense and, in turn, to extend a valuable experience.

"Institutions already having an educational program and, in the present emergency, in need of more trained personnel, are in still better position to participate in this movement.

"After the needs of the Federal hospitals have been met, it is thought that about 15,000 senior cadet nurses will be available, some as early as September, 1943. Federal hospitals will have first call on their services, and it is expected that many hospitals of all sorts will try to get them. Some cannot afford the $30.00 a month. Others are too small to take in enough cadets to furnish the teaching. Our mental hospitals can do both. If a superintendent desires to utilize some of these student nurses and to further their psychiatric training and experience, it is suggested that he get in touch with some school in his own neighborhood engaged in the Federal nurse-training program and make preliminary tentative agreement with the superintendent of nurses of that hospital. This will save the time of the state board.

"Mental hospitals may obtain the services of some of these cadets if they desire to do so, and we know that two or three have been prompt to seize the opportunity. An effective procedure might be to inform your State Board of Nursing Examiners that you wish to par-

ticipate in the program: (1) by receiving (specify the number) senior students; and (2) by providing them $30.00 per month (or more) room, board, laundry, and suitable instruction in psychiatric nursing and ward management."

State Society News

California

Dr. Anna E. Rude, Secretary of the Southern California Society for Mental Hygiene, writes that plans are under way for a community mental-hygiene educational program for the coming winter.

Delaware

Miss Emily O'Malley, Acting Director of the Delaware Society for Mental Hygiene, and Dr. Joseph Jastak, the society's school consultant, have been editing and assembling material for a textbook on "human relations" classes and "social acceptability" testing, according to word received from Miss Eloise B. Tibert, executive secretary of the society. It is hoped that the book will be ready for publication this fall.

Illinois

The Illinois Society for Mental Hygiene has appointed Dr. Rudolph G. Novick as its medical director to take the place of Dr. John Chornyak, who resigned to join the armed forces. Dr. Novick, a graduate of Northwestern University Medical School, has had approximately five years' experience in the Illinois State Hospitals and is a Diplomate in Psychiatry of the American Board of Neurology and Psychiatry. Dr. Novick states that the activities of the Illinois Society for Mental Hygiene are directed along the following channels:

"I. War-time Projects

"A. Services to the armed forces

"1. The Illinois Society, in coöperation with the Illinois Selective Service, has recently completed a neuropsychiatric screening demonstration, and on the basis of the findings of that demonstration project, the Advisory Committee to Selective Service has formulated a state-wide plan for a neuropsychiatric screening program. This plan will be presented in the near future to the governor for his approval. The purpose of the plan is to continue to foster more effective methods of selecting men who are mentally and emotionally fit for the armed services.

"2. The society is continuing to provide counseling for men rejected at the induction center for neuropsychiatric reasons. Although, under the present procedure, no organized effort to direct these men to the society has been instituted, we have from January, 1943, to July, 1943, seen approximately sixty or seventy rejectees. Under the new statewide plan more men will probably be seen because of the improved organizational set-up.

"3. The society is coöperating with other interested agencies in developing a rehabilitation program for men discharged from the armed services as mental casualties.

"4. The society is also coöperating with psychiatrists in various camps with respect to mental-hygiene problems as they affect men in military service.

"B. Service to civilians

The society is continuing a program of interpreting to the public mental-health problems that affect all civilians in wartime. This is being done by means of lectures to various groups and by articles in our *Mental Health Bulletin*.

"II. Peacetime Projects

"A. In addition to its war-time projects, the society is continuing its efforts in the field of mental hygiene that are important during peace time as well as in war. Among these the following may be enumerated:

"1. The society is continuing its interest in the Child Guidance Service League of Sangamon County. The medical director of the society is at the present time making arrangements to provide psychiatric care for the clinic until a full-time psychiatrist may be found.

"2. The society is coöperating with the Health Committee of the Chicago City Club in instituting a mental-health program in the Chicago schools.

"3. The society is in communication with the Peoria Mental Hygiene Society and is attempting to aid them in their problems, especially as regards the lack of a psychiatrist for their clinic.

"B. The society is encouraging the development of mental-hygiene programs in plants, factories, and stores.

"1. The superintendent of Goodwill Industries in Chicago recently approached the society, requesting a plan for the institution of a mental-hygiene program within his plant. This request has been complied with and the Goodwill Industries is now planning to employ neurotic and mild psychotic individuals or individuals who have recently been paroled or discharged from state hospitals. By this arrange-

ment, these individuals will for a time work in a protected environment—either with the hope of regaining their former ability and skill or of being trained for new work—and thus be prepared for work in the large plants and factories under more strenuous and more competitive conditions.

"2. Similar plans for other organizations may be offered to interested groups.

"C. General Counseling

People have problems, no matter what the times. The people who have used our advisory service this year reveal to some extent the general world situation, expressing feelings of insecurity and emotional disturbances as a result of separation from husband and problems with children as a result of the departure of the father for the armed services or the necessity that the mother secure work or that both parents work.

"D. The society is continuing its interest in the care and treatment of the mentally ill.

"1. The Mental Hospitals Committee of the society is at the present time busily engaged in a survey of the state hospitals and in the preparation of a report on the care of the mentally ill in Illinois from 1907 to the present time.

"2. The society has begun a survey of all private sanitaria caring for the mentally ill.

"3. The society has continued to work with the Council of Social Agencies in an effort to extend out-patient facilities.

"E. Legislative Activities

The society is glad to report the passage of the Mental Health Act, which modernizes the commitment laws in the state.

Indiana

Dr. Lillian G. Moulton, Acting Executive Secretary of the Indiana Society for Mental Hygiene, reports that the Indiana Society is assisting in the organization of a local chapter which will probably be known as the Indianapolis Society for Mental Hygiene. It is anticipated that this local society will be followed by other local societies which will, in turn, strengthen the state society.

Maine

Dr. Charles A. Dickinson, Secretary-Treasurer of the Maine Teachers' Mental Hygiene Association, writes that the association is at present issuing a bulletin once a month, the price of which is included in the membership dues. The dues are $1.00 a year if the bulletin is sent to an individual's address; 50 cents a year if five or

more persons join as a group and their bulletins are sent to one address.

Minnesota

Mrs. Carl Lefevre, Executive Secretary of the Minnesota Mental Hygiene Society, reports:

> "Dr. Eric Kent Clarke, Director of the Psychiatric Clinic for Children, University Hospital, is now President of the Minnesota Mental Hygiene Society.
>
> "Dr. Luther E. Woodward, Field Director, Liaison with Selective Service, The National Committee for Mental Hygiene, met with members of the screening committees of Ramsey and Hennepin counties (St. Paul and Minneapolis) on August 5 and 6. Dr. Philip H. Heersema, of the Mayo Clinic, is chairman of the society's Committee on Selective Service.
>
> "The clinical section of the society, organized for social workers of the Twin Cities last year under the chairmanship of Dr. Hyman S. Lippman, Director of the Wilder Child Guidance Clinic, St. Paul, will continue to hold meetings monthly during the fall and winter, except months in which the society is sponsoring another meeting. At the June meeting of the section, it was decided to invite teachers of the Twin Cities to participate during the coming year.
>
> "The first regular meeting of the society will be the annual Judge Waite Lecture on juvenile delinquency, probably to be held in October.
>
> "The society will coöperate with teacher groups in related fields on a luncheon program during the convention of the Minnesota Education Association.
>
> "The executive committee is considering means of developing working relationships to extend the program to industrial mental hygiene and to bring about closer coöperation with the schools."

Pennsylvania

Dr. A. H. Pierce resigned his position as Secretary of the Mental Hygiene and Public Health Division of the Public Charities Association of Pennsylvania in order to become Assistant Superintendent of the Philadelphia State Hospital. His successor has not yet been appointed.

The major project of the Mental Hygiene and Public Health Division of the Public Charities Association of Pennsylvania during the past six months, according to a report recently received from the association, has been the development of a state-wide program to assist in the neuropsychiatric screening of inductees.

> "The Public Chairities Association, through its Mental Hygiene and Public Health Division, has spent many months working with committees in the larger urban centers of the state.[1] Reference centers are being

[1] Some of the cities in which centers have or will be established are Philadelphia, including a five-county area, Pittsburgh, Harrisburg, Wilkes-Barre, Scranton, Reading, Allentown, Bethlehem, Easton, Lancaster, and York.

set up which will clear the names of all men classified as IA with the records of the local social-service exchange, the Bureau of Mental Health in the State Department of Welfare, and county boards of assistance. When pertinent information has been secured from social agencies and institutions that have had contact with these persons, reports are prepared for the medical board at the induction centers. All such information is absolutely confidential, as reports are sent directly to the chief medical officer at the induction station and are seen by no one except by the psychiatrists examining the men. They do not become a part of the selectee's record.

"The establishment of this program in Pennsylvania has been possible only through the splendid coöperation given by General Lewis B. Hershey, Director of National Selective Service, and other members of his staff, Dr. Luther Woodward, of The National Committee for Mental Hygiene, state officials in Pennsylvania connected with Selective Service, state departments of health, welfare, and assistance, and numerous individuals active in social work in various Pennsylvania cities."

Vermont

The Vermont Society for Mental Hygiene has sent out to all air-raid wardens in the state a bulletin giving directions for the care of mentally upset persons during raids. A member of the society has been appointed to the governor's Civilian Morale Committee.

Other activities include support of legislative attempts to delete the words "dangerously insane" from the law dealing with the commitment of individuals to the Vermont State Hospital and of the effort to secure enactment of a law permitting the parole of persons from Brandon State School; support of the development of facilities in arts and crafts at the school; the placing of books on mental hygiene in the Burlington library; and the exhibition of books and posters at summer conferences, etc.

"At present," writes Dr. Elizabeth Kundert, secretary of the society, "the society is occupied with the problems of increasing the membership and of raising funds for mental-hygiene needs. There is a definite need for a paid executive."

Washington

A report on the Washington Society for Mental Hygiene, by Miss Marjorie C. Rice, Executive Secretary, states that on June 1, the society undertook a demonstration study to determine for the state Selective Service System whether a state-wide psychiatric screening program for selectees should be initiated in this state.

"Two local boards—one representing a university, residential area and the other a suburban, rural area—were selected to coöperate in the study. During the first two months' period, the names of several hundred men were cleared through the Seattle Social Service Exchange and the Seattle Public Schools Child Guidance Clinic. More than one-third of the men were known to one or more agencies. Where pertinent data were available, they were forwarded to the induction center. The results were felt to be of enough value to recommend planning for a state-wide program. This planning is now in process, with program initiation expected in the near future.

"The society has taken an active interest in developing an adequate training program for paid personnel in child-care centers. Its executive secretary is Chairman of the Subcommittee on Personnel Training of the Children in Wartime Committee of the State Defense Council. The report of the committee as it concerns personnel qualifications and training was submitted to the state committee. The society has shown considerable interest in the child-care field, for it is felt that personnel is essential for good child care and that this personnel should have adequate knowledge of behavior and counseling resources and community facilities to meet specific problems.

"On October 1, the office of the society will be moved to the Smith Tower, Seattle, where space has been loaned it by the state department. From the standpoint of education and community organization, this offers an excellent opportunity for closer coöperation in the public-health field and for eventual extension of our services on a state-wide basis."

Wisconsin

A quickening of interest in mental hygiene throughout the state as a result of the work carried on in connection with the clearance of Selective Service registrants with health and welfare records, is reported by Dr. Esther deWeerdt, Executive Secretary of the Wisconsin Society for Mental Hygiene, which is the liaison agency for the state Selective Service System and local agencies in the Clearance Project. By the end of September, Dr. deWeerdt writes, approximately two-thirds of the registrants to be called up in the state will be cleared in their counties and with the state institutions through the coöperation of the State Division of Mental Hygiene.

"The Division of Mental Hygiene and the Division of Public Assistance of the State Department of Public Welfare are coöperating actively on the clearance project. In a state which is largely rural, they will through this activity become increasingly important to a mental-health program of a preventive character in the coming months. Fortunately approximately two-thirds of the registrants come from the nine counties that have confidential exchanges. These are coöperating fully. Private agencies have been deeply interested in the project from the start.

"County meetings on the clearance of registrants are bringing together workers from various agencies as well as members of agency boards and

civic groups. These have already had some opportunity to learn of the disturbances in mental adjustment that are traceable to war conditions. A new and intense desire for organized understanding of mental difficulties and for providing the means whereby men and women may be restored, or at least improved, and absorbed again into their community life, is evident. Thus, a keen receptivity to education in mental health has arisen out of local efforts to meet local welfare problems. This is a challenge that this society should take aggressive steps to meet. The public apathy that has allowed our state hospitals and colonies for the feebleminded and epileptic to struggle along for decades without adequate understanding and support is disappearing.

"We are wondering if other states are not experiencing a like arousal of interest in mental health. Certainly veteran groups are keenly aware of the mental hazards of the present war and are seeking assurances of competent care. We are also receiving requests from personnel men in industry and business for assistance in understanding and meeting problems of mental health of workers."

Biographical Directory of the American Psychiatric Association

A limited number of copies of the American Psychiatric Association's *Biographical Directory*, which gives biographical data on over 2,400 members of the association, are available for purchase at the special price of $2.75. They may be ordered from the offices of the American Psychiatric Association, Room 924, 9 Rockefeller Plaza, New York 20, N. Y.

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